NORFOLK COMMUNITY SAFTY PARTNERSHIP

DOMESTIC ABUSE RELATED DEATH REVIEW OVERVIEW REPORT

Report into the death of Simon.

January 2022

Independent Chair and Author: Mark Wolski

Date of Completion: April 2024

Norfolk Community Safety Partnership

The Norfolk Community Safety Partnership and review panel would like to offer their sincerest condolences to those who know Simon. He was remembered by everyone the author spoke to as a caring, kind, and generous person. His personality leant itself to his professional career, providing support within the care sector. He was loved by his family and friends and will be missed.

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GLOSSARY

Abbreviation / Acronym	Full meaning
AAFDA	Advocacy After Fatal Domestic Abuse
BACP	British Association of Counselling and Psychotherapy
CGL	Change Grow Live
CSEW	Crime Survey England and Wales
DARDR	Domestic Abuse Related Death Review
EINA	Equalities impacts needs assessment
GP	General Practitioner
ICB	Integrated Care Board
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer, intersex, and asexual
N & W	Norfolk and Waveney
NCSP	Norfolk Community Safety Partnership
NIDAS	Norfolk Integrated Domestic Abuse Service
NNUH	Norfolk and Norwich University Hospital
UKPC	United Kingdom Council for Psychotherapy

1. INTRODUCTION

1.1 Domestic Abuse Related Death Reviews (DARDRs), formerly DHRs, were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.2 This report of the DARDR (hereafter 'the review') examines agency responses and support given to Simon, a resident in Norfolk prior to the point of him taking his own life in **January 2022.**

1.3 Following the incident, police were contacted suggesting that Simon's partner Thomas had been abusive to him throughout their relationship, and that he had known Simon was going to take his life and could have prevented the tragic events.

1.4 The circumstances were considered by a local DARDR Gold Meeting hosted by the Office for Police Crime Commissioner for Norfolk in February 2022. The panel recommended a DARDR be commissioned and this was agreed by the Chair of Norfolk Community Safety Partnership (NCSP).

1.5 This review was commissioned by the NCSP to consider agencies contact/involvement with Simon and Thomas from **January 2019 to January 2022** (around the time of Simon's death). In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before Simon took his own life, whether support was accessed within the community and whether there were any barriers to accessing support.

1.6 The period was selected to encompass a sufficient period to understand Simon and Thomas's relationship and by reference to Simon's medical chronology. The panel retained the option for extending the relevant period to encompass a period when they had parental responsibility for children associated with a previous relationship of Simon's. This was dependent upon on their engagement which was not possible.

1.7 The primary purpose for undertaking DARDR is to enable lessons to be learned from homicides where a person has or appear to have died as a result of domestic violence and abuse. In this case, where Simon had taken his own life, there was a reported history of domestic incidents at the home address and information had been received alleging that Simon had been abused by Thomas. This gave rise to a concern that a review should be undertaken, even though no one was charged with homicide. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand the circumstances leading up to Simon's death, what happened when agencies had involvement with her during the relevant period, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.8 This review process does not take the place of the criminal or coroner's courts, nor does it take the form of a disciplinary process.

1.9 The review also reflects the views and thoughts of some of Simon's family who contributed to this review. The Panel wishes to express their sincere condolences to them and all of Simon's family.

2. TIMESCALES

2.1 The NCSP commissioned this review in accordance with 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'. The Home Office were notified of the decision in writing on 17th February 2022.

2.2 Home Office guidance states that a review should be completed within six months of the initial decision to establish one. There was an initial delay as the commissioner of reviews undertook a round of advertising before a suitable chair was appointed in May 2022. In this case, further delays arose following police investigations related to allegations by family of coercion and control perpetrated by Thomas with Simon as the victim. Given the basis of the decision to conduct a review, the nature of the allegations made by third parties with whom the chair would wish to speak, the chair advised that the review should be paused to prevent the risk of compromising any police investigation. The panel agreed and the review was paused, pending the conclusion of police enquiries.

2.3 Further delays related to, - securing medical chronology for Thomas with consent, - identifying and engaging with Thomas's counsellor with consent, - attempts to identify and then engage with Simon's counsellor, - conversations with the respective accreditation agencies for those counsellors.

2.4 Final delays resulted from meeting with Simon's family and partner in March 2024 and subsequent amendments to the overview report.

2.5 The Home Office have been kept appraised of subsequent delays in progressing the review.

3. CONFIDENTIALITY

3.1 Details of confidentiality, disclosure and dissemination were discussed and were agreed between Panel Member Agencies at the first Panel Meeting.

3.2 All information discussed was agreed as strictly confidential and was not to be disclosed to third parties without the agreement of the responsible Agency's Representative.

3.3 All Agency Representatives agreed to be personally responsible for the safe keeping of all documentation that they possess in relation to this DARDR and for the secure retention and disposal of that information in a confidential manner.

3.4 NCSP provided a secure information platform for the purposes of sharing information.

3.5 To protect the identity of family members, with the agreement of family members, the following anonymised terms and pseudonyms have been used throughout this review.

Table 1

Pseudonym	Relationship	Age at the time of the incident	Ethnicity
Simon	Deceased	42	White British
Thomas	Partner	60	White British
Margaret	Sister of deceased	u/k	White British
Doris	Aunt	u/k	White British

4. TERMS OF REFERENCE

4.1 The full terms of reference are set out at **Appendix A**. This review aims to identify the learning from a suicide associated with alleged domestic abuse. In determining the key lines of enquiry, the panel took into account Simon's life as a gay man who had previously had diagnosis of mental illness and was a partner in a business with his husband.

Key Lines of Inquiry

A. Analyse the **communication and co-operation** which took place within and between agencies regarding Simon.

B. Analyse the opportunity for agencies to identify and **assess risk of domestic abuse** or **suicide ideation/self-harm**, including what would have enabled or hindered disclosure.

C. Analyse agency **responses to any identification of domestic abuse or suicide ideation/self-harm.**

D. Analyse organisations' **access to specialist domestic abuse agencies**.

E. Analyse the **policies, procedures, and training** available to the agencies involved, with regard to domestic abuse, self-harm/suicidal ideation.

F. Analyse any evidence of **seeking help**, as well as considering what might have **helped or hindered access to help and support**. *(That includes what barriers there were to Simon, Thomas, friends, and family seeking help)*

G. Explore the **strategic approach to domestic abuse in respect of male victims** and those in same sex relationships.

H. The extent to which **Covid-19** effected agency involvement with Simon.

I. **Equalities**: The Review Panel will consider all protected characteristics

5. METHODOLOGY - REVIEW PROCESS

5.1 Legal Framework

5.1.1 The Review has been conducted following Statutory Guidance under S9(3) Domestic Violence, Crime and Victims Act (2004) and the expectation of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016.

5.2 Methodology Overview, Panel Meetings, Individual Management Reviews (IMRs) and Chronologies

5.2.1 Following the decision to undertake a DARDR, NCSP agencies were asked agencies to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek chronologies initially, followed by IMRs for all the organisations and agencies that had contact with Simon and Thomas.

5.2.2 Agencies who had contact with Simon and Thomas are summarised below.

Table 2

Agency	Trace of Simon	Trace of Thomas	Input
GP Practice	Yes	Yes	Chronology and IMR
Norfolk and Norwich University Hospital	Yes	No	Chronology and IMR
Norfolk Constabulary	Yes	Yes	Chronology and factual report
Norfolk Children's services	Yes	Yes	N/A
Change, Grow, Live	Yes	No	Chronology and factual report

5.2.3 The input from Norfolk Children's Services was dependent upon consent of children placed into the care of Simon. This consent was either not given or not available.

5.2.4 An integrated chronology produced by NCSP was reviewed at the first panel meeting on 23rd June 2022 that enabled a draft Terms of Reference to be agreed. This was kept under review throughout the review process.

5.2.5 The chair gave a bespoke IMR briefing to authors, providing an overview of the DARDR process, and writing an IMR, in line with Home-Office guidance (Home Office 2016).[1]

5.2.6 In addition to the IMRs, documents reviewed during the review process have included:

- BACP – Good practice in action briefings
- GP/ICB Safeguarding Policy
- National Suicide Prevention Strategy 2023-2028
- Norfolk Domestic Abuse Strategy 2022 -2025
- Norfolk Support in Safe Accommodation strategy 2021-2024
- Norfolk Community Safety, Domestic abuse Strategy 2022-25
- Norfolk County Council Equalities Impact Assessment for the Safe Accommodation Strategy
- UKCP Code of Ethics and Professional Practice
- UKCP Standards of Education and Training (2017)

5.2.7 In addition to panel meetings (summarised at 8 below), the chair also held individual meetings with panel representatives to explore technical details and seek clarification on several matters.

5.2.8 As the review progressed, the chair learned that Simon had been seeking counselling from a private counsellor locally. The chair contacted the counsellor and received no response. Similarly, NCSP wrote to them, asking for them to contribute. No response was received. The chair tried again in May 2023, and the counsellor asked not to be contacted again.

5.2.9 The chair contacted the professional body that provides accreditation to Simon's counsellor, the British Association of Counselling and Psychotherapy. As a result, he met with the Registrar and Head of Professional Standards in June 2023. They were able to provide an overview of the policies and ethical standards to which registered counsellors work and forwarded relevant papers for a sense check. Analysis and commentary are included under a section entitled 'Counsellor for Simon'.

5.2.10 Following the delays owing to criminal investigations, there were further delays as the chair attempted to speak to wider friends and family. In May 2023, in a second interview with Thomas, he provided permission for his medical records to be examined, and he also explained that he had seen a private counsellor. The chair approached this counsellor and met with her in June 2023. She had been registered with the United Kingdom Council for Psychotherapy. Analysis and commentary are included under a section entitled 'Counsellor for Thomas'.

6. FAMILY INVOLVEMENT

6.1 Simon was one of four children, three boys and one girl. Simon had been close to his sister Margaret and the chair was also able to speak to her occasionally during the review process. She gave permission for her statement to police to be disclosed but at a point informed the chair she no longer wished to take part in the review, until the chair recontacted her and met her in March 2024. The Chair was also able to speak to his aunt over a period of months who was supported by AAFDA, and she gave permission for her statement to police to be disclosed. However, in June 2023, as the review progressed, she decided that she no longer wished to take part in the review until she met the Chair along with Margaret

[1] Source: DARDR-Statutory-Guidance-161206.pdf (publishing.service.gov.uk)

in March 2024. Simon was estranged from one of his brothers, and the other brother was not involved in the review process.

6.2 Simon was understood to have had one child Alex[2] (Not real name) from a brief relationship, who was brought up by their mother. The mother of this child went on to have more children. Simon and Thomas briefly had parental responsibility for Alex and two other children for two years prior to the relevant period.

6.3 Norfolk Community Safety Partnership initially wrote to the only relatives for whom contact details were available, that included: his husband Thomas; his sister Margaret and a close friend in April 2022. The letters provided information about reviews and details of support agencies including Advocacy After Fatal Domestic Abuse. The chair sent a follow up letter in May 2022, also repeating the information about support agencies.

6.4 NCSP attempted to contact the children but did not receive any response. As the review progressed, the chair did manage to speak to one adult child who declined to take part in the review.

Table 3

Status	Outcome
Child (Alex)	Didn't respond to NCSP letter
Step – child (1)	2nd February 2023; declined to take part
Step – child (2)	Didn't respond to NCSP letter

6.5 A full schedule of contact with all friends/family is outlined at **Appendix B.**

7. CONTRIBUTORS

7.1 IMRs or Factual Reports were requested from agencies as shown at table 2 above, as being proportionate to the purposes of the review.

8. REVIEW PANEL

8.1 The Review Panel comprised of agencies from the Norfolk area, as Simon and his partner were living in that area at the time of his death. Agencies were contacted as soon as possible after the review was established to inform them of the review, their participation, and the need to secure their records. LGBT+ Norfolk was invited to form part of the panel but declined to take part.

Table 4

Name	Agency	Role
Mark Wolski	Chair	Independent Chair/Author
Amanda Murr	OPCC – Norfolk	Assistant Director Policy and Partnerships
Angela Johnson	NNUH	Named Nurse Safeguarding Children and Domestic Abuse Lead
Charlotte Richardson	NIDAS	Service Manager *(From Panel 4 in lieu of Sandy Lovelock)*
Gary Woodward	N&W ICB	Designated Professional for Safeguarding Adults
Liam Bannon	OPCC – Norfolk	Community Safety Manager

[2] Note: In late 2023 Thomas found documentary evidence in the form of a DNA analytical report that found Simon was not the father of Alex. This was reportedly never discussed by Simon with Thomas nor wider family. The chair has confirmed that the whole family and children have been made aware of this development.

Mark Brooks	Mankind Initiative	Chairman
Maria Karretti	N&W ICB	Named GP for Safeguarding Adults
Matthew Armitage	Change, Grow, Live	Complex Needs & Think Family Team Leader, Designated Safeguarding Lead
Pippa Hinds	Norfolk Constabulary	Detective Superintendent, Safeguarding & Investigations Command
Sandy Lovelock	Leeway Domestic Violence and Abuse	Temporary Accommodation Coordinator
Sue Marshall	Public Health Norfolk	Safeguarding and Partnership Manager
Tina Chuma	NNUH	Lead Professional for Safeguarding Children and Vulnerable Adults

8.2 The review panel met a total of six times, with the first meeting 22nd June 2022, and subsequent meetings on the 19th October 2022, 8th March 2023, 7th November 2023 and 8th April.

8.3 Agency representatives were of appropriate level of expertise and were independent of the case.

8.4 The Chair of the review wishes to thank everyone who contributed their time, patience, and co-operation during this review.

9. AUTHOR AND INDEPENDENT CHAIR

9.1 The Chair of the Review was Mark Wolski. Mark has completed his Home Office approved Training and has attended subsequent Training by Advocacy After Fatal Domestic Abuse.

9.2 Mark is a former Metropolitan police officer with 30 years operational service, retiring in February 2016. During and since his MPS service Mark has had no personal or operational involvement with NCSP. He has had several DARDR's published from across England. See Appendix C for a full statement of independence.

10. PARALLEL REVIEWS AND RELATED PROCESSES

Coronial Proceedings

10.1 The inquest into Simon's death was suspended pending the outcome of the review. The Coroner was kept appraised of the progress of the review.

11. EQUALITIES AND DIVERSITY

11.1 The nine protected characteristics as defined by the Equality Act 2010 have all been considered; they are age, disability, sex, sexual orientation, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief and sexual orientation.

11.2 At the first meeting of the Review Panel, it identified that the protected characteristics of Sex, Sexual Orientation and Disability were pertinent to this review.

Sex and Age

11.3 Simon was male. An analysis of DARDRs reveals gendered victimisation across both intimate partner and familial homicides with females representing the majority of victims and males representing the majority of perpetrators.[3]

11.4 The ONS reports that males accounted for three quarters of suicide deaths in 2020[4], the most recently published report. Therefore, males are more likely to take their own lives with the ONS reporting that 'since around 1990, men have been at least three times as vulnerable to death from suicide as women'.[5] At an annual rate of 5,000 deaths per year by suicide, this equates to approximately 14 men every day die by suicide).

11.5 The Suicide prevention strategy in England: 5-year cross sector strategy highlights "Men are 3 times more likely to die by suicide than women, with middle-aged men having the highest rates of suicide of any other group (based on age and sex) since 2010".[6]

Disability

11.6 Disability was considered as it was apparent that Simon had lived with mental illness for a long period of time. The Human Rights Act 2010 defines disability as "A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities".[7] This is supported by the government view that says, "A mental health condition is considered a disability if it has a long-term effect on your normal day-to-day activity. This is defined under the Equality Act 2010"[8].

11.7 The panel kept these definitions in mind, owing to the enduring nature of Simon's condition and well established links between, disability, domestic abuse and suicide. For example, a Public Health publication Disability and domestic abuse[9] explains *'Disabled people experience disproportionately higher rates of domestic abuse. They also experience domestic abuse for longer periods of time, and more severe and frequent abuse than non-disabled people*'. For example, according to Disability Rights, disabled people are more likely to die by suicide than non-Disabled people according to 2021 Census data and *"For men, the figure for Disabled men was over three times higher – 48.36 deaths by suicide per 100,000 people compared to 15.88 deaths by suicide per 100,000 people for non-disabled men*[10]**.** In addition, the importance of looking at the relationship between domestic abuse and suicide has recently been highlighted by a recent study conducted by Kent and Medway. They found that "30% of all suspected suicides locally are individuals who have been impacted by domestic abuse (either as a victim or perpetrator)".[11]

Sexual Orientation

11.8 Simon was married to Thomas, living in a same sex relationship. The panel agree the relevance of sexual orientation, as there are several studies that suggest increased prevalence of domestic abuse in same sex relationships. In a US study "Violent Victimization by Sexual Orientation and Gender Identity, 2017–2020", it reported '*The rate*

[3] Source: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf (Accessed October 2021)
[4] Source: Suicides in England and Wales - Office for National Statistics (ons.gov.uk) (Accessed February 2023)
[5] Source: Who is most at risk of suicide? - Office for National Statistics (ons.gov.uk) (Accessed June 2023)
[6] Source: Suicide prevention in England: 5-year cross-sector strategy - GOV.UK (www.gov.uk) (accessed October 2023)
[7] Source: https://www.equalityhumanrights.com/en/equality-act/protected-characteristics#disability (Accessed February 2023)
[8] Source: When a mental health condition becomes a disability - GOV.UK (www.gov.uk) (Accessed February 2023)
[9] Source: Microsoft Word - Disability and domestic abuse topic overview FINAL.docx (January 2025)
[10] Source: Disabled people far more likely to die by suicide than non-disabled people | Disability Rights UK
[11] Source: Article: Why are people impacted by domestic abuse dying by suicide? (nspa.org.uk) (Accessed November 2022)

of violent victimization of lesbian or gay persons (43.5 victimizations per 1,000 persons age 16 or older) was more than two times the rate for straight persons (19.0 per 1,000)'[12]. The GP IMR author also highlighted this phenomenon, as noted within the analysis section.

11.9 A Safelives spotlight on 'LGBT+ people and domestic abuse' found that LGBT+ victims of domestic abuse are almost twice as likely to have attempted suicide (28% versus 15%).[13] The panel noted that the language in respect of people's sexual orientations and gender identities is evolving. Therefore, where possible the acronym LGBTQIA+[14] will be used throughout the report unless another acronym is used from a quoted source.

11.10 A recent government policy paper entitled "Supporting Male victims" highlighted 'The CSEW for year ending March 2020 highlights that gay and bisexual men were around twice as likely to experience domestic abuse as heterosexual men'.[15] ONS figures showed the rate for heterosexual men as 3.5% versus for gay men at 6%.[16]

11.11 The panel has paid due regard to these protected characteristics for two reasons. The first, recognising the importance of the Equalities Act and the duty on public authorities to;

- remove or reduce disadvantages suffered by people because of a protected characteristic.
- meet the needs of people with protected characteristics.
- encourage people with protected characteristics to participate in public life and other activities [17]

11.12 The second owing to the need to consider whether intersectionality was apparent, that is the theory that various social identities contribute to systemic discrimination.[18]

12. DISSEMINATION

12.1 The Executive Summary and Overview Report were approved by Norfolk Community Safety Partnership (NCSP) and were subsequently sent to the Home Office for quality assurance.

12.2 The Executive Summary and Overview Report will be shared by the Office of the Police and Crime Commissioner for Norfolk with the following.

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- Simon's family.
- Chief Constable, Norfolk Police
- Chief Executive, Norfolk County Council
- Chief Executive, Leeway
- Chief Executive Officer, Norfolk, and Waveney Clinical Commissioning Group (now N & W Integrated Care Board)
- Chair, Norfolk Health and Wellbeing Board
- Domestic Abuse Commissioner
- Independent Chair, Norfolk Safeguarding Adults Board
- Norfolk Police and Crime Commissioner
- Simon's GP practice

[12] Source: Violent Victimization by Sexual Orientation and Gender Identity, 2017–2020 (ojp.gov) (Accessed February 2023)
[13] Source: Spotlight #6: LGBT+ people and domestic abuse | Safelives (Accessed February 2023)
[14] LGBTQIA+ - LGBTQIA+ is an acronym that stands for lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and others.
[15] Source: Supporting male victims (accessible) - GOV.UK (www.gov.uk) (Accessed May 2023)
[16] Source: Domestic abuse prevalence and victim characteristics - Office for National Statistics (ons.gov.uk) (Accessed October 2023)
[17] Source: https://www.citizensadvice.org.uk/law-and-courts/discrimination/public-sector-equality-duty/what-s-the-public-sector-equality-duty/ (Accessed February 2023)
[18] Source: https://www.dictionary.com/browse/intersectionality (Accessed February 2023)

12.3 The action plan will be monitored by NCSP Community Safety Team will be responsible for monitoring the recommendations and reporting on progress".

13. BACKGROUND INFORMATION - THE FACTS

13.1 Simon was one of four children, three boys and one girl. His parents had passed away and he had become estranged from one of his brothers but remained very close to his sister (Margaret).

13.2 Simon had lived in Norfolk with Thomas for several years. Having met in 2008, they were married in 2014. Simon had one child (see 6.2) from a brief relationship in the year 2000 who was brought up by their mother who went on to have more children who were fostered by Simon and Thomas

13.3 Simon and Thomas had contact with the children as they were growing up, and in 2016, the some of the children were put into a fostering placement with Simon and Thomas. The children moved on before the relevant period for this review.

The Events of Simon's death

13.4 In January 2022, police were called to a report of a possibly deceased male inside a car at public car park, having been discovered by a member of the public. Police and ambulance service attended and found Simon, with a handwritten note to Thomas stating sorry, and stating that an email had been sent to him, along with his phone number. Emergency services attempted CPR, but life was pronounced extinct.

13.5 The Chair has been provided a copy of the email that is summarised below.

> Simon first apologised to the emergency services, explaining that whilst he appeared to have a privileged life, it had been a life full of sadness and trauma, and a belief that there was further trauma to come.
>
> He continued with a note to the pathologist about the pain he had been experiencing, providing a description of symptoms and Simon's sense that the pathologist would find something.
>
> Simon then wrote to his uncle and aunt (who the chair met in a family meeting in March 2024), explaining how difficult he would find it to lose them.
>
> He wrote to Thomas that he should take notice of what his behaviour does, but that he did not blame Thomas, but that what he wanted was to be taken care of 'just a little bit'. Simon then said all he wanted was a hug from his mum and to be told everything would be ok, and that the only thing that would have come close was for Thomas to have done the same and to look after him.

13.6 The following day, Simon's sister called the police reporting that Thomas had been abusive towards Simon throughout their relationship and that Thomas knew that Simon was going to take his own life. She reported that Simon sent messages to Thomas telling him that he was going to kill himself, suggesting that Simon's death could have been prevented. She explained that they were going through a divorce, despite living at the same address.

13.7 The events of Simon taking his own life were subject to investigation by the criminal investigation department, concluding that the incident was not suspicious, resulting in a report being submitted to the coroner.

13.8 The Chair has been provided with a copy of the coroner's postmortem report that attributed Simon's death to methadone toxicity.

14. CHRONOLOGY

14.1 The chronology is broken down into two sections, the first being background according to friends and family. The second is the narrative chronology that relates to contact with agencies.

14.2 **Background – Family and Friends**

14.2.1 The Chair was able to have an initial conversation with Simon's partner Thomas in May 2022, before delays were enforced by police investigations and a desire not to interfere with criminal justice processes. Once concluded the Chair was able to re-engage in 2023. The chair was able to have initial conversations with his sister Margaret, and his aunt Doris who was supported by AAFDA, before both decided they no longer wished to take part in the review.

14.2.2 The summaries provided are the personal views and recollections of those spoken to. Consent has been granted for their inclusion.

Partner – Thomas

14.2.3 There were delays in the chair interviewing Thomas owing to police investigations into an allegation of control and coercion by Thomas in respect of Simon. The chair initially spoke to him in May 2022, and after police had concluded investigations, he spoke to Thomas again and he provided consent for his GP to provide a chronology for the relevant period.

14.2.4 Thomas also provided copies of email traffic from Simon in 2015 to various people, which indicate long standing suicidal thoughts.

- July 2015 entitled 'To be read in the event of my death', describes how he felt lost without his mum.
- He describes business difficulties including income flow and problems with HMRC. The email describes what should happen to his estate. It also continues with a note to Thomas about how much he loved him.
- Simon also describes how the previous 8 years had been the happiest years of his life.
- November 2015: entitled 'Funeral plan'. This sets out brief instructions around coffin and crematorium music.
- November 2015: Entitled 'Updated funeral plan'. A briefer email with changes to arrangements
- December 2015: Entitled 'Insignia and I love you'. A further lengthy email, talking about HMRC, the pressure he was experiencing, and apologizing to Thomas.

Sister – Margaret

14.2.5 The following summarises relevant recollections from Margaret.

Margaret described how Simon and Thomas had met via social media and the relationship had developed very quickly.

Pen Picture Simon
She described Simon as an exceptionally caring person, who would do anything for anybody and was dedicated to his work, caring for children with complex needs.

Relationship
She described the relationship as toxic between Simon and Thomas. She found Thomas very controlling, providing examples that she had also reported in her statement to the police, including preventing Simon from sleeping to the extent Simon had to find elsewhere to sleep. She described that she had found Thomas hostile when visiting, making distasteful comments, and she found that he kept telling Simon how to do things.

Stressors
She described the impact of bereavement including the loss of Margarets son in January 2019, and their father in June 2021, and said that Thomas had not provided the emotional support one would expect.
On exploring stressors in Simon's life, this had included health worries and how unsupportive Thomas had been. Otherwise, a significant stressor in his life had been his desire to get a divorce from Thomas.
Margaret also explained that Simon had been seeking a divorce, but that he could not, because he was being pressured to sign everything over to Thomas.

Events before the incident
In the run up to and over the Christmas period 2021, Margaret described a series of text conversations between she and Simon detailed in a police statement, which reflect the breakdown in the relationship.
In her police statement, she says that Simon had sent an email to Thomas stating his intention to kill himself and failed to act on the email.

Seeking Help
She spoke about how Simon had sought help from a local counselling service but was unsure of whether Simon had disclosed the behaviour of Thomas. She said that she had advised him to go to the police. She said that if it were a woman the police may have listened, but he (Simon) felt they would not listen to a man.

Aunt - Doris

14.2.6 The following summarises relevant recollections from Simon's aunt.

Pen Picture/Characterisation.
She described Simon, as 'the most loving, generous person that any person could wish to have around. He loved his family; he would do anything for anybody. He was the sort of person, who could walk in and talk to anybody. If he saw someone who was sad, he would hug them.
She said that he was very passionate about his business, looking after children who had complex needs. She explained this was Simon's passion, and his business received referrals from the local council. She believes the business had been set up with a birthday gift from Thomas.

Relationship
She described Simon and Thomas as being completely opposite, with Simon as caring, and Thomas as not being demonstrably caring/affectionate.
She described a very controlling and emotionally abusive relationship as opposed to physically abusive. She said that Thomas went for Simon as soon as people had left the house. She described accounts of him preventing Simon sleeping, resulting in Simon frequently leaving the house to sleep. She also described, controlling what Simon did, such as blocking the drive with his car, when Simon was due to go out socially.

Stressors
She describes periods of grief including when her own son was diagnosed with cancer, and Simon had been immensely supportive, and then when Simon's father was in hospital and passed away. She felt that Thomas did not provide the support/compassion to Simon he needed.
She said that he had been trying to leave the marriage for many years, having led separate lives, and Simon had filed for divorce about 4 years ago, but at the time couldn't proceed as Thomas refused to sign the divorce papers. However, matters changed, and Simon was waiting for the divorce to come through when he took his own life.

Events before the incident

Three days before the incident, they had gone to a funeral, and she came back with him. When they returned, Thomas went into another room. She then went to talk to Thomas about not supporting Simon. She then sat with them both for four hours trying to sort out their situation. Simon said he could not do this anymore. In the following days, she called him every day, and the day before he took his life, she asked how things were, and Simon said apart from taking the Christmas tree down together things were back to normal, with Thomas just staring at Simon.

On the day, she was driving to see Simon and passed him going the other way. She tried to call Simon, but he did not answer. When she went to the house, Thomas wasn't there. She phoned Thomas and he said they had another row, and Simon had taken off. She suggested calling the police, but Thomas had been insistent that she didn't.

Reflections.
She explained that she had a professional background in relation to sexual abuse, having worked in a crisis centre, and so she reflected the need for support agencies to raise their profile, and encouraging people to have confidence in the police.

She also expanded that there was a need for better trauma informed care, and less reliance on medication to treat symptoms.

14.2.7 The following summarises relevant recollections from friends of Simon and Thomas.

Pen Picture/Characterisation

Simon was described as an incredibly bright and intelligent man, who followed the care industry with great interest. He was also described as being a very generous person whether in the workplace or entertaining.

It had been clear to friends that he had a close relationship with his parents, and particularly his mother. Hence, he had been badly affected by the loss of his mother and the father.

He appeared to be a very determined character who would not shy away from a challenge, an example being how he had expressed his dissatisfaction with a hospital who were treating his father, raising complaints with the ward, before escalating to the Chief Executive.

Relationship

A reflection from friends was that Simon had appeared to be the person in charge and the relationship had been unhappy for some time, with Simon sometimes disappearing, such as when he went to Scotland by himself one week. He would sometimes go and sleep on the floor of his dad's bungalow, or in a lodge that was owned by the company.

In the knowledge that the relationship was in difficulty one friend had suggested that Simon see a counsellor to talk about the relationship and believes he had attended but did not know what the outcomes was.

No-one had witnessed any domestic abuse, physical or emotional.

One friend reflected that when Simon had told them of an impending split, Simon had suggested that Thomas would need a lot of support. The friend recalled that Thomas was a very down to earth Norfolk person and Simon would be the person needing a hug and that perhaps Thomas could not give that type of support. This reflected a comment by another friend who had recalled that Simon had felt all alone, notwithstanding he had a husband, siblings, cousins, and friends.

Events before the incident

They recalled that Simon had gone on holiday just before Christmas (to the Caribbean) with a friend, then had Christmas, and that then he took his life.

Health

Friends did not recall any incidents of self-harm or previous suicide attempts. They were unaware of any diagnosed physical or mental health issues, though one commented on him not feeling well for some time and smoking a lot.

One friend commented that Simon was just immensely sad, that reflects the other friends comment about Simon having felt all alone.

14.3 Narrative Chronology – Key Contacts with Agencies

Prior to the 'relevant period'

14.3.1 ***NHS Crisis Plan***: The chair was provided with a copy of a crisis plan from 2005, that summarised he problem as "Simon is severely depressed and has attempted suicide by driving to a remote spot with a large quantity of tablets. He has given the tablets to his parents. He continues to experience strong suicidal thoughts currently. He feels guilty in that he incorrectly perceives that he has caused his predicament. He also feels a burden on others.[19]

14.3.2 ***GP:*** Simon registered at his GP practice on 19th September 2013. In 2005, aged 26, Simon was diagnosed with bipolar affective disorder; a mental health condition which causes a person's mood to swing from one extreme to the other (low and elevated mood). In 2008, he was diagnosed with chronic fatigue syndrome (a long-term condition causing multiple physical and psychological symptoms including extreme tiredness, sleep and memory problems, dizziness, headaches, muscle, and joint aches). The GP notes indicate he had high blood pressure, mild asthma, and migraines.

14.3.3 In November 2004 aged 25 years, Simon took a deliberate overdose of antidepressant and blood pressure medication and was admitted under Section 5 of the Mental Health Act 2005 which was regraded to a section 2. Simon's sister recalled this related to a previous relationship where there had been domestic abuse against Simon. The outcome of this admission is not clear. Further incidents of self-harm include;

- July 2005, he attempted suicide by carbon monoxide poisoning.
- July 2006, he took an overdose of Depakote (antipsychotic medication).
- August 2006, he took an overdose of multiple unspecified medication.

14.3.4 In 2015, Simon was referred to the Mental Health crisis team following the death of his mother. The records showed that he talked happily about his relationship but reported stress regarding a company that he owned.

14.3.5 The context of these incidents is not known however the notes indicate there were no further suicide attempts until Simon's death in January 2022.

14.3.6 Simon had been prescribed opiate medicines by the pain clinic for longstanding generalised pain. In February 2019 Simon was prescribed methadone for management of opiate withdrawal. The GP offered a referral to the drug and alcohol service for support to taper off the use of methadone, but he declined this as he felt his addiction was as a consequence

[19] Source: PDF/faxed copy of report from Norfolk Mental Health Care Trust. Forwarded by partner Thomas.

of therapeutic necessity and not illicit drug use. Simon reported he had researched well and wished to reduce the methadone himself.

2019

14.3.7 ***GP:*** (February to June) Simon had six contacts with the practice including in person and telephone consultations. The focus of these related to medication and a reduction in methadone that had been prescribed in relation to opiate withdrawal following chronic pain. He was signposted to Change Grow Live (CGL) in March, but was reluctant to engage because of the associated stigma, his rationale being that his addiction was a consequence of therapeutic necessity.

14.3.7 ***Change Grow Live***: CGL received the referral on the 26th of March 2019. They wrote to him, and subsequently closed the case in May as Simon did not contact them.

14.3.8 Further consultations in this period related to managing the symptoms of withdrawal such as insomnia and 'restless legs'. Simon was prescribed diazepam following discussion around the potential of addiction, and it was noted that he planned to speak to CGL.

14.3.9 At his June appointment he had two consultations with the GP, the second following a telephone conversation between CGL and Simon in respect of tapering his medication.

14.3.10 Simon also attended the clinical neurophysiology department at NNUH, undergoing an EMG, the results of which were normal, with no evidence of continuous muscle activity.

14.3.11 ***GP and NNUH:*** (October to December) In October Simon informed the GP that he was off all opiates and that work, and home life was good, but had developed loose stools which he felt were a side effect of withdrawal from years of opiate use. He was referred to Gastroenterology and underwent a bowel camera test at NNUH (sigmoidoscopy) and other tests which did not find anything abnormal.

14.3.12 During this period, Simon reported elevated blood pressure, attending the practice for an ECG, and being given a blood pressure machine for monitoring. He was diagnosed with stage 1 hypertension.

14.3.13 ***GP:*** Thomas had five contacts with his GP for matters that are not pertinent to this review.

2020

14.3.14 ***GP & NNUH:*** (January to June) Simon had multiple contacts with his GP and departments within NNUH, many of which related to ongoing night sweats/fever. Simon expressed concerns that he may have Parkinsons, as this had been in his family, and he underwent a number of tests during this period. In late June, Epstein Barr Virus was detected and following discomfort and swelling in the neck, and some abdominal pains, Simon was dealt with promptly within the cancer care pathway, undergoing, blood tests, x-rays, and ultrasounds across the departments of the hospital. These did not result in any diagnosis.

14.3.15 ***GP:*** On 27th May, during a consultation, he said that he was living with his husband and foster son and working as a care coordinator in mental health.

14.3.16 ***GP & NNUH*** *:* In July, he had three contacts with his GP, regarding ongoing symptoms and on the 16th July he did present at the Ambulatory Emergency Car Assessment Unit of NNUH, following further night sweats, and following further tests and no confirmed diagnosis was reached During the latter half of the year, the frequency of contact diminished with his GP and hospital, undergoing a variety of tests that were inconclusive.

14.3.17 ***GP:*** Simon did not have cause to attend his GP during this period, and all contacts related to repeat prescriptions that are not related to this review.

14.3.18 ***GP:*** Simon continued to report the longstanding symptoms, seeing his GP on 25th January 19th April, 20th July, 5th October, 1st and 19th November complaining of a variety of physical symptoms. A range of screening tests were undertaken, with no clear diagnosis. In November Simon said that he had learned to live with the symptoms, and it was noted microbiology were exploring the potential of symptoms being associated with animals at Simons home address/land. Simon had 4 dogs, 60 chickens and guinea fowl that roamed the garden.

14.3.19 ***Private Counselling Service (Thomas):*** Thomas attended private counselling sessions on four occasions, 14th, 24th September, 8th and 29th October. Thomas sought advice about having been described as a narcissist.

14.3.20 ***NNUH***: Simon had sporadic contact with the hospital regarding blood tests. In December he cancelled two general surgery appointments on the 8th and 20th December, respectively.

14.3.33 ***GP****:* Thomas attended his GP on one occasion, and had one telephone consultation in 2021, regarding matters unrelated to this review.

15. OVERVIEW

The summaries below relate to agencies with whom which he had significant contact during the relevant period and have completed IMRs or a factual report.

15.1 General Practitioner (GP)

15.1.1 Having registered at the practice in 2013, during the relevant period he had multiple contacts during the relevant period, initially related to tapering off opiate dependency related to longstanding generalised pain, thereafter related non-specific symptoms that required undergoing several diagnostic screening tests. No formal diagnosis was arrived at, though traces of Epstein-Barr virus (A viral infection which commonly causes glandular fever[20]) were found.

15.2 Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH)

15.2.1 Simon was an NNUH patient under different specialties as an outpatient and day case patient between January 2019-January 2022. Simon was seen by the Gastroenterology, Ear Nose Throat (ENT), and Neuro-Physiology teams for varying symptoms that included management of night sweats; pain in his neck; abdominal cramps; diffuse muscle spasms; at times chest pain and muscular tightness around the left side of his chest which would then temporarily gradually spread to the arms, abdomen, legs, and jaw; fatigue; frequent loose stools. He underwent various tests and investigative surgical procedures which came back negative and clear from any new serious medical diagnosis. Simon's symptoms were managed with various medications to help to manage them.

15.3 Counsellor for Simon

15.3.1 Simon's counsellor has declined to become involved and asked the chair not to contact them. The chair is therefore unable to comment on their engagement with Simon but can comment on the ethical standards of counsellors in accordance with the body to whom she was accredited by the British Association for Counselling & Psychotherapy.

[20] Source: Epstein-Barr virus - Newcastle Hospitals NHS Foundation Trust (Accessed January 2025)

15.4 Counsellor for Thomas

15.4.1 Thomas's counsellor saw him on four occasions between September and October 2021. The reason for seeking counselling was because his soon to be ex-partner (Simon) had accused him of being a narcissist, and Thomas wanted to understand himself better. She found him to be a self-sufficient, stoic character who kept his emotions and real self hidden.

16. ANALYSIS

The analysis of this review explores the reasons why events occurred, how and whether information was shared and, subsequently, whether the sharing informed decisions and actions taken. This section is broken down into three parts, the definition of domestic abuse, an analysis overview, and a detailed analysis against the lines of enquiry.

16.1 Domestic Abuse Definition

16.1.1 This review is undertaken in accordance with Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews

16.1.2 The government definition of domestic abuse within that guidance is: - Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence, or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited, to the following types of abuse: psychological, physical, sexual, financial, emotional.

16.1.3 Controlling behaviour is defined as: - A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

16.1.4 Coercive behaviour is defined as: - An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

16.1.5 In April 2021, the Domestic Abuse Act received Royal assent and provided a statutory definition of domestic abuse that is shown at appendix D but otherwise summarised as: - *Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if A and B are each aged 16 or over and are personally connected to each other, and the behaviour is abusive. Behaviour is abusive if it consists of any of the following; (a) physical or sexual abuse, (b) violent or threatening behaviour, (c) controlling or coercive behaviour, (d) economic abuse, (e) psychological, emotional or other abuse; and it does not matter whether the behaviour consists of a single incident or a course of conduct.*

16.2 Analysis Overview

16.2.1 To try and understand why this tragic event took place, the panel has attempted to consider events from the perspective of Simons' lived experience. These are considered in terms of his life, but also a framework of factors that contribute to suicide risk. In this case a US site, the 'Centers for Disease Control and Prevention' provides a framework of individual, relationship, community, and societal risk factors.[21] Some of these factors were or may have been present during the relevant period and/or earlier. These include: -previous suicide attempt, - history of depression and other mental illness, - financial problems and substance misuse.

Bipolar and Suicide

16.2.2 Simon had a history of having attempted to take his own life, his mood swings were apparent to his partner, and his low mood and sense of hopelessness/desperation is clear in his last communication. This posed a challenge to the panel, as there is no sense that

[21] Source: Risk and Protective Factors | Suicide | CDC (Accessed February 2023)

this low mood was apparent in agency dealings with him in the months before his death. Last consultations/visits to practice GP were on (27.10.2021, 01.11.2021, 18.11.2021, 19.11.2021, 14.12.2021)

16.2.3 Simon had been diagnosed with bipolar disorder, and the information suggest numerous attempts to take his own life. There appear to be several articles suggesting an increased likelihood of death by suicide. One article by Lancaster University references '*It has been estimated that as many as 10% of Bipolar Disorder patients die by suicide, and as many as 40% report having made suicide attempts'*.[22] In a Danish study highlighted by the BBC, it found that deaths from suicide were higher from people with bipolar disorder.[23] The actual study over 4 decades found the suicide risk was highest in bipolar disorder at 7.77%, versus 0.72% for non-symptomatic patients.[24] In other words, nearly ten times higher.

Previous Attempts to Take his Own Life

16.2.4 Whilst attempts to take one's own life are a recognised risk factor, the information available shows that no previous attempts were made during the relevant period. One may therefore be tempted to consider that the risk diminishes over time. However, studies indicate that this is not the case, with one study reporting, "the suicide rate for those who had attempted it once was 5.9 attempts per 1,000 people per year for the five years after the first try; 5.0 attempts per 1,000 people per year 15 to 20 years after the first try; and 6.8 attempts per 1,000 people for the final three years". In other words, the rate of attempting suicide does not decline over time.[25]

Bereavements/Trauma

16.2.5 The accounts of the family, and Simon's narrative in relation to the loss of his mother demonstrate the traumatic effect on him. (See 13.5: *The only things I want in the world are my mum to hug me and tell me things will be okay*). Such was the effect on him that the fear of future bereavements had a profound affect when talking about people close to him (See 13.5 *I can't go through losing either let alone both of you. I can't face that reality I'll be so alone*) again demonstrated in his email to Thomas.

Domestic Abuse and Suicide

16.2.6 The importance of looking at the relationship between domestic abuse and suicide was highlighted at 11.7 above.

16.2.7 Furthermore in December 2022, the Home Office in conjunction with the College of Policing published, "Vulnerability Knowledge and Practice Programme (VKPP) Domestic Homicides and Suspected Victim Suicides 2021-2022" that contains a series of recommendations. Given the evidence above, the panel's attention was drawn to Recommendation 12.

- *We recommend that, in developing local and national suicide prevention activities, health agencies should consult domestic abuse specialists to ensure that appropriate measures relating to domestic abuse victims are included. At a local level, Local Health Partnerships should consider the risk of suicide following domestic abuse in their Domestic Homicides and Suspected Victim Suicides 2021-2022 suicide prevention strategies. At a national level, the Department for Health and Social Care should ensure that domestic abuse is reflected in national suicide prevention strategies*.[26]

16.2.8 However, domestic abuse was not disclosed in any of Simon's interactions with health agencies. This is explored within the individual agency analysis, in respect of recognition of risk factors, and policies/practice regarding routine enquiry.

[22] Source: Suicidality-and-Self-Harm - Lancaster University (Accessed January 2025)
[23] Source: Stephen Fry: Suicide risk in bipolar disorder - BBC News (accessed February 2023)
[24] Source: Absolute Risk of Suicide After First Hospital Contact in Mental Disorder | Psychiatry and Behavioral Health | JAMA Psychiatry | JAMA Network (Accessed February 2023)
[25] Source: Suicide: The Risk is Lifelong For Those Who've Tried It Once | HealthyPlace (Accessed February 2023)
[26] Source: *[Title] (vkpp.org.uk) (Accessed January 2023)

Causes of Suicide

16.2.9 The short analysis of factors above reflects a report 'Tackling Male Suicide' by an all-party parliamentary group on issues affecting men and boys[27] that identified three intertwined issues of, - external factors (Stressors), - universal issues, - transitions. Examples under each category are shown below.

Stressors	Relationship breakdown, financial concerns, bereavement, isolation
Universal issues	Social integration, loss of meaning and purpose, gap in available and signposted male friendly services, lack of professional curiosity
Transitions	Family, relationship loss, sexuality, bereavement

16.2.10 The review found that many of these featured in Simon's life, reflecting that there was no one single cause for Simon's death.

National Suicide Prevention Strategy 2023-2028[28]

16.2.11 As the review was ending, the national strategy was published that highlights middle-aged men as a priority group and that domestic abuse is an additional risk factor for all victims.

Domestic Abuse and Male Victims

16.2.12 Whilst women are statistically more likely to be a victim of domestic abuse, the panel recognised the importance to view the circumstances from a male victim perspective. In so doing, the panel considered a number of articles. The first, an article 'Domestic abuse during Covid-19; What about the boys', provides a useful perspective from which to start, suggesting that a considerably lower number of men confide in someone about their experience.[29] A further research study[30] identified a number of matters to consider as reflective of Simon's experience:

- *Recognizing and accepting. This theme relates to men's denial of their abuse. The issue of abused men being unable (or unwilling) to recognize and accept their victimization featured heavily in participant accounts. In part, this was accounted for by the lack of knowledge or awareness by men as to what constitutes DVA victimization, fear of not being believed, and shame of admitting being abused:*
- *Outcomes and impact of abuse. Participants referred to the extensive impact of abuse experienced by men. This included isolation, long-term physical problems, poor mental health (including feeling suicidal), and loss of contact with their children:*
- *Outcome and impact of disbelief and expectations. This theme depicts the consequences of men not being readily accepted as victims of abuse by others (e.g., police and family courts). Disbelief that men can experience abuse, notions of what a victim is, a reluctance or inability to see themselves as victims/claim victim status, coupled with societal expectations of men may mean that men face further victimization when they seek help:*

16.2.13 The panel noted a recent comment by the Domestic Abuse Commissioner," We know *that men face specific challenges when it comes to domestic abuse. Harmful gender norms, shame or honour, and stereotypes of masculinity and sexuality can act as barriers for male victims and survivors to seek support and can impact on reporting*".[31] Evidence of the additional barriers men are confronted with may be drawn from the 2018 crime survey for England and Wales that reported just over half of male victims of partner abuse (50.8%) reported telling anyone personally about abuse experienced in the previous year. This compares to the 81.3% of female victims.[32]

[27] Source: Inquiry No 3: Male suicide. - Equi-law UK (Accessed October 2023)
[28] Source: Suicide prevention strategy for England: 2023 to 2028 - GOV.UK (www.gov.uk) (Accessed October 2023)
[29] Source: Domestic Abuse during COVID-19: What about the boys? - PMC (nih.gov) (Accessed March 2023)
[30] Source: "I Have Guys Call Me and Say 'I Can't Be the Victim of Domestic Abuse'": Exploring the Experiences of Telephone Support Providers for Male Victims of Domestic Violence and Abuse (sagepub.com) (Accessed March 2023)
[31] Source: Our support for male victims - Domestic Abuse Commissioner (Accessed November 2022)
[32] Source: Partner abuse in detail, England and Wales - Office for National Statistics (ons.gov.uk) (Accessed June 2023)

16.2.14 These findings perhaps reflect the existence of rigid gender role expectations placed upon men, commonly referred to as hegemonic masculinity that may be characterised by independence and stoicism. An article in Science Direct quotes how in western societies such masculinity is synonymous with a 'macho' identity that includes '*stoic in the face of adversity. It is thereby viewed as associated with behaviours that display courage and strength and that include refusal to acknowledge weakness or to be overcome by adverse events'*.[33]

Strategic Approach to Domestic Abuse – male victims and those in same sex relationships

16.2.15 One of the key lines of enquiry for this review relates to the strategic approach to domestic abuse in respect of male victims. To analyse the local strategic approach, the chair was provided with a copy of the Norfolk Domestic Abuse Strategy 2022-2025 and has accessed several local websites.

Norfolk Domestic Abuse Strategy 2022-2025

16.2.16 The strategy acknowledges that men experience domestic abuse, and that "*there is stigma for men related to the societal assumption that domestic abuse victimisation is gendered, which can act as a barrier to male victims and survivors reporting*". What is less clear is how the five strategic priorities of the strategy translate to support for male survivors of domestic abuse. However, under the sub-section 'Improved Partnership Understanding,' it states, "*A point of focus will be to improve understanding of domestic abuse and sexual violence for LGBTQIA, ethnic minority communities, the effects on family members, other protected characteristic groups, and those with complex needs*."

16.2.17 Within the section, 'Supporting victims and survivors and responding to perpetrator', the strategy recognises the aspiration for inclusivity, stating '*Services for domestic abuse victims and survivors in Norfolk must be inclusive. The diverse population that the partnerships serve make it imperative that support is accessible and meets the needs of all protected characteristic groups, including but not limited to LGBTQIA and ethnic minorities."*

16.2.18 Arguably, it may be useful to have identified males within those subsections, though the panel recognise the clear strategic direction re LGBTQIA+ communities. The chair was also provided with a range of focused LGBTQIA+ information material from 2021 and 2022 (See Appendix E), that further demonstrates local commitment to tackling domestic abuse in same sex relationships. These are recognised as good practice.

Support in Safe Accommodation Strategy for Norfolk 2021-2024[34]

16.2.19 The strategy provides a comprehensive overview of the context, what the strategy intends to achieve and how it will be delivered. The context section provides a summary of the local needs assessment, clearly stating that men make up 25% of all DA victims. It furthermore highlights a number of gaps including; "*There is no specific safe accommodation provision for male survivors but as there is an under-recording of demand, either in terms of support or use of safe accommodation, we are unable to determine the amount of safe accommodation that may be required for male victim-survivors",* and concludes *"Refuges are unlikely to meet the needs of males".*

16.2.20 The strategy does have a section on addressing gaps in need but does not state how it will address the needs of male victims. However, under the section 'our ambition' it states clearly, "*Norfolk develops a model of satellite refuge / safe accommodation across Norfolk to address current gaps which can be sustained and increased if needed over time. The accommodation will be: • Open to male and female, LGBTQIA victim-survivors over the age of sixteen and their children. Ensure accessibility to ethnically diverse communities."* This statement of intent is welcome.

[33] Source: Hegemonic Masculinity - an overview | ScienceDirect Topics (Accessed August 2023)
[34] Source: Support in Safe Accommodation Strategy for Norfolk 2021-2024 (Accessed February 2023)

16.2.21 This strategy also summarises support available and references the Daisy Programme in support of all people in the locality of Breckland. The strategy also references NIDAS, as the locally commissioned provider and single point of contact for domestic abuse services.

NIDAS

16.2.22 NIDAS provides advocacy support for medium and high-risk victims of domestic abuse and signposts those at standard risk to other organisations. Upon exploration outside panel meetings, the panel were reassured that they benefit from a 'Men's' specialist IDVA and an LGBTQIA specialist IDVA from April 2023. A dip sample of clients in the calendar year 2022 showed a broad correlation between NIDAS clients who were LGBTQIA+ and the Norfolk population (2.48%[35] v 2.66%[36]). The provision of a men's specialist is recognised as good practice.

Equalities

16.2.23 Whilst Equalities is a Line of Enquiry for this review, the panel's attention was drawn to recently revised guidance, "The Essential Guide to the Public Sector Equality Duty", published in March 2022[37] that describes the duty and considerations that includes, "Take steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people". Simon was a man, in a same sex relationship, and therefore the intersection of these characteristics was important for the review to contemplate. The Chair requested a copy of the local Equalities Impact Needs Assessment used to inform local delivery and was informed that a formal assessment had not been completed. However, the chair was provided with a copy of the Equalities Impact Assessment (EIA) that has informed the local Safe Accommodation Strategy that shows a broad understanding of the local implications of accommodation provision for those with protected characteristics.

16.2.24 Whilst the needs of men and LGBTQIA victims are recognised and catered for (16.2.17), not completing such an assessment risks the needs of victims with protected characteristics not being addressed and a lack of clarity how those needs are met. (16.2.13). The importance of comprehensive Equalities Impact Assessments in Norfolk is brought closer into focus by a GALOP report entitled "An isolated place", that reported "Compared with those in the major queer cities (37%), LGBT+ survivors living in a village (54%*) or any other city (50%*) at the time of the abuse were more likely* to report they did not know any supports were available".[38]

Learning opportunity (LO1): NCSP ensure that Equalities Impact Needs Assessments are routinely completed, with an associated action plan that ensures that needs of diverse groups (in this case, men) are identified and acted upon. **Recommendation 1**: NCSP to ensure that an EINA and action plan is completed in relation to future Domestic abuse strategies.
Outputs/Outcomes: - EINA and action plan that identifies needs of different categorisations of victims are identified, recognised, and where gaps exist subject to proportionate action planning, - Strategy that shows how male and LGBTQIA+ victims are supported

[35] Source: NIDAS performance data from Norfolk County Council
[36] Source: Census reveals how many LGBTQIA people live in Norfolk | Eastern Daily Press (edp24.co.uk) (Accessed May 2023)
[37] Source: guidance-essential-public-sector-equality-duty-england_0.docx (live.com) (Accessed August 2022)
[38] Source: Galop_A4_IsolatedPlace_Report_2023_Final.pdf (accessed May 2023)

Age Difference

16.2.25 The panel were cognisant of Simon being 18 years younger than Thomas. The panel kept in mind and sought to understand whether there was the potential for Thomas to have greater control through his life experience/maturity, or whether there was any dependency reducing Simon's status in the relationship and whether social and cultural norms about an age difference creating barriers to Simon having sought help.

16.2.26 It is against the background of these deliberations that the analysis of agency interactions was considered. To ensure a comprehensive analysis, each agency section is structured to follow the 'Lines of Enquiry.'

16.3 General Practitioner (GP)

16.3.1 Simon had around twenty-three consultations of which nine were on the phone during the relevant period. Notably fifteen of these contacts with one GP, and four with another. The BMJ reported "Patients who see the same GP are less likely to be admitted to hospital for certain conditions, researchers at the Health Foundation have found".[39] In Simon's case, it may be argued that seeing one GP enabled him to build a relationship and trust, avoiding the need to repeat his story multiple times. This is recognised as good practice.

Line of Enquiry (LOE1) – Communication and Co-operation between agencies

16.3.2 Simon was seen by the surgery in relation to several ailments, during the relevant period. In March 2019, he was offered a referral to Change Grow Live (CGL) to assist with managing his reduction in methadone, and it was his decision not to engage as he felt that his addiction was a consequence of therapeutic necessity as opposed to illicit drug use. However, the practice did facilitate a conversation between CGL and Simon with a discussion on withdrawal symptoms, and a shared decision was reached to 'watch and wait'. This interaction shows good communication and cooperation between agencies.

16.3.3 The GP also made multiple referrals to specialists at NNUH to investigate his physical symptoms, and the records show reciprocal communication with the outcomes of those referrals.

Line of Enquiry (LOE2) – Risk Assessment for domestic abuse and suicide ideation/self-harm

16.3.11 On considering Quality Standard 116 of NICE guidelines relating to asking about domestic violence and abuse, it is noted that a list of symptoms or conditions of possible domestic violence and abuse commence with; - symptoms of depression, anxiety, post-traumatic stress disorder, sleep disorders; - suicidal tendencies or self-harming and alcohol or other substance misuse.

16.3.12 Whilst Simon had been previously diagnosed with bipolar disorder, none of his consultations during the relevant period reflected concerns about his mental health, low mood, or suicidal ideation. Throughout this period, he presented with physical symptoms only, such a 'restless legs, shooting pains and dizziness', and no evidence of trauma.

16.3.13 Arguably his treatment and advice about reducing his methadone may be considered a substance issue matter, and during the period, issues of sleeping problems was apparent (30/05/19). However, on none of these occasions was he asked about abuse or did further exploration as to his home circumstances become necessary.

16.3.14 The panel reflected on the limited contact, and note that a comment was made in 2019, about 'life being good', and in 2020, it seems he spoke about his husband, and his foster son and work. Whilst no details are recorded, it may be inferred that there had been good

[39] Source: Seeing same GP is linked to fewer hospital admissions | The BMJ (Accessed March 2022)

conversation about the context of Simon's life and an opportunity for him to have disclosed any concerns either in respect of domestic abuse or self-harm.

16.3.15 However, whilst there were no overt concerns about Simon's mental health, nor his social situation, the chair drew the panels attention, to further subjects listed under QS116 as indicators of possible domestic violence or abuse that are pertinent when considering Simon's presentation to clinicians. These are; - Unexplained gastrointestinal symptoms; - repeated health consultations with no clear diagnosis. Clearly applying these lists poses the risk of utilising the counsel of perfection that is hindsight bias but does provide an opportunity for reflection that is further explored below (under LOE5 – Policy).

16.3.16 In addition to the information presented at 11.6 regarding prevalence of domestic abuse among gay couples, the IMR reported, "Studies have also identified the existence of intimate partner violence among lesbian and gay couples, and its incidence is comparable to (Turell 2000) or higher than that among heterosexual couples (Messinger 2011, Kelley et al. 2012)". This was also noted at 11.6. An individual agency recommendation has been made to raise awareness of this fact.

Learning Opportunity/Reflection (LO2): To raise awareness of rates of intimate partner violence among LGBTQIA+ communities.

Individual agency recommendation: To raise GP awareness of the existence of intimate partner violence among lesbian and gay couples and its incidence can be higher than that among heterosexual couples.

Line of Enquiry (LOE3) – Response to domestic abuse – suicide ideation/self-harm issues

16.3.17 Neither domestic abuse nor self-harm were apparent during the relevant period.

Line of Enquiry (LOE4) – Access to specialist agencies

16.3.18 The GP practice has a safeguarding lead GP for children and a safeguarding lead GP and adults as well as a domestic abuse change champion who has undertaken the required 2-day training. The core training includes a resource pack that includes details of NIDAS (Norfolk Integrated Domestic Abuse Service), Leeway (Domestic abuse service for Norfolk and Suffolk), and the National Domestic Abuse helpline number. The chair also noted that the existence of domestic abuse champions demonstrates the ongoing learning from previous DARDR's. The local case of 'Stephanie' made a recommendation, 'That GP practices across the county consider having Domestic Abuse Champions in their surgery'[40]

16.3.19 The practice has a safeguarding policy dated 5th October 2021 and last reviewed 29th September 2022 with a dedicated section on domestic abuse. Information about the local domestic abuse services Leeway and NIDAS are referred to in the policy including referral routes.

Line of Enquiry (LOE5)– Policies, Procedures & training re domestic abuse

16.3.20 The chair was provided with a copy of the practice GP Policy dated May 2022 and a revised version dated May 2023 written by the Norfolk and Waveney Integrated Care Board which acknowledges that domestic abuse also occurs against men in heterosexual relationships, in same sex relationships and against bisexual and transgender people.

16.3.21 There is a clear flow chart of action to take about domestic abuse, and 'enquiry', including the sentence "*There is currently insufficient evidence to recommend screening or routine enquiry however a low threshold is recommended when appropriate".* Whilst there is a

[40] Source: DARDR-Stephanie-Executive-Summary-MAY2018.pdf (norfolk-pcc.gov.uk) (Accessed February 2023)

reference to NICE guidelines, the chair suggests a subtle change of language may encourage the 'duty to ask'.

16.3.22 NICE guidelines list a range of indicators of possible domestic abuse; starting with symptoms of depression, anxiety, PTSD.[41] Quality Statement 1: Asking about domestic violence and abuse references these indicators, and what the indicator means for service providers, "Health and social care practitioners recognise indicators of possible domestic violence and abuse and respond appropriately. They make sensitive enquiries of people presenting with indicators of domestic violence or abuse about experiences as part of a private discussion and in an environment in which the person feels safe".

16.3.23 On considering routine enquiry in greater depth the panel explored several contradictory reports on the efficacy of routine enquiry. Whilst the Cochrane report found a two-fold increase in identification of Domestic Abuse, it also found that there was no increased uptake in accessing specialist provision and concluded there was insufficient evidence to justify implementation of IPV screening for all women in healthcare settings.[42] However, the British Journal of General Practice reports "evidence suggests that routine or universal healthcare screening for DA improves levels of victim identification in primary care settings".[43] However, this study does evidence improved identification, versus the statement in the policy.

16.3.24 Paragraph 292, of the statutory guidance for the Domestic Abuse Act says, *"Health and social care service managers and professionals should ensure trained staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children, and vulnerable adults' services ask service users whether they have experienced domestic abuse. This should be a routine part of good clinical practice, even where there are no indicators of such abuse"*.[44] It was also noted that the policy would benefit from updating definitions in accordance with the Domestic Abuse Act.

16.3.25 The BMJ in an article 'Routinely asking women about domestic violence in health settings' says *"A systematic review of screening for domestic violence in healthcare settings concluded that although there was insufficient evidence to recommend screening programmes, health services should aim to identify and support women experiencing domestic violence. The review highlighted the importance of education and training of clinicians in promoting disclosure of abuse and appropriate responses. We argue that a strong case exists for routinely inquiring about partner abuse in many healthcare settings"*[45]. This point is reinforced by the observations made at 16.3.15 in respect of recognising indicators of abuse.

Learning Opportunity (LO3): To ensure that local GP domestic abuse policies are updated in accordance with recent changes in legislation, guidance, and research regarding enquiry about domestic abuse. **Recommendation 2:** Update the template DA policy, bringing it up to date with changes in legislation, so as to encourage professionals to recognise indicators of, and routinely ask about domestic abuse.
Outputs/Outcomes: More patients asked about domestic abuse, and records reflect this routine enquiry. More patients signposted to domestic abuse support services

16.3.26 The IMR author reported that all staff complete and refresh safeguarding training online to a level dependent on their role in line with the Intercollegiate documents for Safeguarding

[41] Source: Quality statement 1: Asking about domestic violence and abuse | Domestic violence and abuse | Quality standards | NICE (Accessed February 2022)
[42] Source: Source: Screening women for intimate partner violence in healthcare settings | Cochrane/ (Accessed February 2023)
[43] Source: Routine screening for domestic abuse | British Journal of General Practice (bjgp.org) (Accessed February 2023)
[44] Source: Domestic Abuse Statutory Guidance (publishing.service.gov.uk) (Accessed February 2023)
[45] Source: Routinely asking women about domestic violence in health settings | The BMJ (accessed February 2023)

children and adults. The non participatory part of training can be completed on the "e-learning for healthcare platform." In addition, clinical staff attended monthly safeguarding meetings where cases are discussed and reflected upon.

Line of Enquiry (LoE6)– What helps or hinders accessing help and support.

16.3.27 As noted at 16.3.14, it seems that the GP did make enquiry about Simon's life, indicating a supportive GP/patient relationship. He was not asked directly about domestic abuse.

16.3.28 Evidence of the supportive relationship is clear in the treatment of methadone reduction, in a planned and collaborative manner between patient and GP, with clear evidence of a tapering schedule having been agreed. Simon was offered support by CGL, and whilst he initially declined engagement, in follow up consultations, the GP was able to facilitate a telephone consultation between CGL and Simon, to provide expert advice on withdrawal. The GP was also able to support through the specialist referrals for withdrawal symptoms that were occurring.

16.3.29 Whilst there was no cause during the relevant period to refer or signpost Simon for support regarding abuse or self-harm, the analysis did note Simon was not assessed in accordance with best practice, every two weeks during the period when the amount of methadone being used was tapered down (11th February to 9th October 2019). This has been subject to an individual agency recommendation.

(LO4) Learning Opportunity: Ensuring patients who are reducing dependency on methadone, are assessed every two weeks.

Individual Agency Recommendation: To raise GP awareness of NICE guidance and Faculty of Pain Medicine guidance on supporting people who wish to withdraw from methadone and other opioids including regular review and recognising the withdrawal symptoms and how to enquire about these.

16.3.30 The IMR author reported, all staff complete and refresh safeguarding training online to a level dependent on their role in line with the Intercollegiate documents for Safeguarding children and adults. The non-participatory part of training can be completed on the e-learning for healthcare platform. The clinical staff attended monthly safeguarding meetings where cases are discussed and reflected upon.

Line of Enquiry (LoE7) – Strategic Approach to Domestic Abuse – Male victims

16.3.31 The policy document, provides information as to where men experiencing domestic abuse should seek support. Wider strategic considerations are discussed at 16.2.14.

Line of Enquiry (LoE8) – Impact of Covid

16.3.32 There does not appear to have been any overt adverse impact of Covid on Simon.

Line of Enquiry (LoE9) – Equalities

16.3.33 The matters reported at 11.6 (rates of domestic abuse in same sex relationships) and 11.7 (rates of suicide in LGBTQIA+ community) are noted, as is the recent research at 16.2.6 (rates of suicide where those taking their own lives had been impacted by domestic abuse).

16.3.34 Simon did not present with overt signs of abuse, nor did he disclose domestic abuse at any point, and he presented solely with longstanding non-specific physical symptoms. In the absence of any disclosure of domestic abuse, the GP surgery prioritised the investigation of these longstanding physical symptoms to exclude a sinister organic cause in this young man.

16.3.35 The panel did reflect on wider societal expectations, whether the intersection of gender(Simon as a man), sexuality(Simon as a gay man) and unconscious bias may have played a part in Simon not being asked about abuse, as domestic abuse can be described as a woman's issue with one article *suggesting "Intimate partner violence (IPV) or domestic violence (DV) is often framed as a "woman's issue" or "violence against women" generating the perception of males involved in violent relationships as the aggressor and more capable of inflicting injury or causing harm to their partner"*.[46] There was no evidence of this perception being present. Whilst physically unwell, and he was not asked about domestic abuse, challenges in respect of mental health were not apparent in the relevant period and there was no evidence to suggest he was treated differently because he was a gay male.

16.3.36 The panel also considered the importance of the overlapping of factors together with unconscious bias described above; - rates of domestic abuse in LGBTQIA+ communities' – rates of suicide in LGBTQIA+ communities, - recent research linking suicide to impact of domestic abuse. Whilst the research findings are clear, the panel did not conclude that the interconnected nature of these factors collectively resulted in any impact as to how Simon was treated, though recognise the importance of ensuring wider awareness of these factors.

16.3.37 Notwithstanding this, as the review progressed, the panel representative has changed the policy to make it absolutely clear that, domestic abuse occurs in all social classes, cultures, and age groups including men, women, non-binary, lesbian, gay, bisexual, and trans (LGBTQIA+) whatever the sexual orientation, mental or physical ability. Changes include the deletion of reference to asking routinely for woman attending the practice for cervical smears. The panel welcome the fast time in which such changes have been made.

Comment regarding medication.

16.3.38 A question was asked by the family about how it could be possible for Simon to have stockpiled medication, and so further enquiries were made of the GP and police.

16.3.39 It is understood that Simon died from 'methadone toxicity'. Therefore, detail was sought about prescriptions. It was reported Methadone had been issued since 14th February 2012 until 17th May 2019.

16.3.40 The panel considered guidance in respect of 'stockpiling drugs'. The panel were informed the practice requests patients to return any unwanted/unused medication to a community pharmacy for disposal. Specifically, the panel were informed that the CQC advises "Staff need to take steps to prevent issuing prescriptions once they are aware that the patient no longer needs the controlled drug. The practice repeat prescribing policy must include these steps.". General practice conducts regular medication reviews with patients on repeat medication and can identify if a patient is over-ordering or under-ordering repeat medication which will prompt a GP/clinical pharmacist review. Comments earlier demonstrate that reviews were being undertaken regularly and, in this case, it is a fact that the prescriptions were being tapered down and therefore would be unlikely to have considered a risk of Simon stockpiling drugs.

16.3.41 A request was made for further details of medication found on scene, and the information available states that it was methadone prescribed to Simon and an open packet of other prescription medication in the name of a third person. However, all the tablets were present.

16.3.42 It is therefore concluded that further scrutiny by the practice in relation to prescription of methadone would not have changed the tragic course of events, over 2 years after the prescription ended. Moreover, it is noted that he had in his possession other medication prescribed to another and would have had access to other non-prescribed substances that may be fatal if ingested in significant quantities.

[46] Source: Source: Male Victims of Domestic Violence. By Don Dutton and Katherine White | NCFM, Australia (Accessed March 2023)

16.4 Norfolk and Norwich University Hospital (NNUH)

16.4.1. Simon attended the hospital on fourteen occasions under different specialities during the relevant period and was subject to tests and exploratory procedures. He did not attend the emergency department and had not since he had attempted to take his life in 2004.

Line of Enquiry (LoE1)– Communication and Co-operation between agencies

16.4.2 Simon had contact with various departments including Gastroenterology, Ear Nose and Throat and Neuro-Physiology teams. There was effective communication between primary and secondary care in the form of a typed summary of the appointment that includes patient`s previous history, current symptoms, overview and opinion of the management, possible diagnosis, and next steps/plan.

Line of Enquiry (LOE2) – Risk Assessment for domestic abuse and suicide Ideation / self-harm

16.4.3 There were no concerns recorded on any of the medical notes following Simon's appointments at NNUH in relation to his mental health or signs of domestic abuse. The chair explored with the panel representative whether 'flags' were used in relation to mental health, and it was explained there were not. It was suggested that the inclusion of any such markers may present a GDPR challenge, as mental health covers a wide spectrum from low to significant concerns, and one would have to consider the point at which such a line would be drawn. Moreover, there would also be an ongoing requirement to review relevance and amend in accordance with data protection regulations that would be logistically challenging. On considering Simon's circumstances, a strong case could not be made given the historic nature of attendance regarding mental health concerns and suicide.

16.4.4 The panel's attention was drawn by the author of their factual report, to the NNUH Domestic Abuse policy states if staff receive a disclosure of domestic abuse or if they have reason to suspect it, they are to discuss with the patient further, including the completion of a DASH (Domestic Abuse, Stalking, Harassment and Honour Based Violence) assessment if appropriate. They are also to make the relevant referrals with consent, without consent if there is a justifiable reason to override consent.

16.4.5 The subject of policy is discussed below but is relevant in the regard of considering 'if' 'domestic abuse is disclosed, as opposed to enquiring about such abuse. The panel's attention was once again drawn to QS116 (as for GP), and a list of indicators of possible domestic violence and abuse that does include; - Unexplained gastrointestinal symptoms; - repeated health consultations with no clear diagnosis. Clearly Simon lived with these concerns, and once again required the panel to reflect on opportunities for improved curiosity, as opposed to applying the counsel of perfection that is hindsight bias, and drawing the conclusion that clinicians should have asked. The matter of policy is subject to further commentary below.

16.4.6 On considering why staff may not have shown enhanced professional curiosity to ask questions about potential abuse, or perhaps not identified the signs, the British Journal of Nursing posed the question as to what the barriers were and concluded, *"Several barriers to screening by health professionals were identified, including lack of training, education, time, privacy, guidelines, policies and support from the employer, with the most prevalent of these being a lack of training and education"*.[47] The IMR author has also concurred there remains a need to promote professional curiosity, and is also aware of the recommendations contained within DARDR Sarah recently concluded by the same chair, that contained individual agency recommendations and an overarching recommendation.

[47] Source: What barriers prevent health professionals screening women for domestic abuse? A literature review | British Journal of Nursing (magonlinelibrary.com) (Accessed March 2022)

Whilst not conflating DARDRs, the panel agree it important to reference these here. The recommendation below from DARDR Sarah is shown below the specific learning opportunity.

(LO5) Learning Opportunity: To improve professional curiosity of professionals through recognition of possible indicators of domestic abuse.

Response: See DARDR Sarah recommendation. A Norfolk DARDR.

Learning Opportunity: To improve the recognition and response to signs of domestic abuse, demonstrating improved professional curiosity and asking about domestic abuse, by ensuring policy and training requirements are in place.

Individual agency recommendations (Sarah):

- Review policy to ensure that there is enough information contained within the policy to enable the identification of DA and to increase practitioners' knowledge around professional curiosity.
- A review of the Level 3 training packages to ensure more information is provided to teams on professional curiosity and how to ask the questions around DA will need to be undertaken by the Safeguarding team considering this DARDR investigation.

Whilst the trust has identified these recommendations, the overall recommendation below for other agencies, encapsulates these points. It is noted here for completeness only.

Recommendation: Seek to improve the ability of clinicians to identify signs of domestic abuse and respond with appropriate professional interest that provides opportunities for survivors to disclose abuse

16.4.7 There was nothing held within the records suggesting that Simon had been asked about his mental health, nor that there were any indicators of concern that would have required further interest and professional curiosity. This also reflects GP records at the time. The only admission to NNUH from poor mental health was in 2004.

Line of Enquiry (LOE3) – Response to domestic abuse – suicide ideation/ self-harm issues

16.4.8 Neither domestic abuse nor self-harm were apparent during the relevant period.

Line of Enquiry (LOE4) – Access to specialist agencies

16.4.9 Whilst domestic abuse was not asked about, or identified, the trust has ready access to Norfolk Integrated Domestic Abuse Service, MARAC, and all specialist services via appropriate referral. In addition, From April 2024 there has been an addition to NIDAS which includes two Health IDVAs based within the Norfolk and Norwich University Hospital and the Queen Elizabeth Hospital, Kings Lynn. The purpose of the health IDVAs is to raise awareness of domestic abuse across the hospitals, and to support the hospital staff with identifying and responding to domestic abuse. The health IDVAs also raise awareness of the 2-day Domestic Abuse Champions training that is facilitated by NIDAS. Since this report was submitted to the Home Office for quality assurance, the health based IDVAs at NNUH and QEH are no longer in position.

16.4.10 The NNUH teams also have access to trained Domestic Abuse Champions across their wards and departments. The panel learned that champions meet on a quarterly basis and receive update training and supervision during these sessions. The DA Champions role is to raise the profile and awareness of DA within their department areas and to support their teams with DASH[48] completion when the need for this is required. This is recognised as positive practice.

[48] DASH: The Dash risk checklist is used by Idvas and other frontline professionals to identify and assess risks when a potential victim discloses domestic abuse, 'honour'- based violence or stalking. Dash risk checklist and FAQs - SafeLives

Line of Enquiry (LoE5)– Policies, Procedures & training re domestic abuse

16.4.11 The Trust has a policy for the Management of Reporting Incidents of Domestic that provides a useful pathway where abuse is suspected or disclosed. As acknowledged earlier that whilst there were signs of domestic abuse, these were not identified and nor does the policy require routine enquiry. The IMR author has identified an opportunity to improve professional curiosity, and concurs with recommendations of DARDR Sarah, as noted above.

16.4.12 The panel learned that all clinical staff undertake level 3 training including a whole day's face to face "Think family" safeguarding training which includes, an hour dedicated session on DA, with an additional session covering Female Genital Mutilation, Honour Based Abuse & Forced marriage. All other staff undertake level 2 safeguarding training which briefly covers DA. Notwithstanding this training, there were several potential indicators of domestic abuse (See 16.4.5), that were not recognised. Whilst these were not overt, indicating a more fundamental reminder, and training about recognising signs of abuse. Work has commenced in relation to an individual agency recommendation from DARDR Sarah shown below.

Learning Opportunity: To enhance the training regarding domestic abuse, ensuring staff are able to recognise and respond signs of abuse.

Individual agency recommendation: To review information, contained within the level 3 training package (face to face and e-learning) around Professional Curiosity and how to ask the questions around DA, and Embed any additional information that's required to facilitate an increase in staff knowledge and understanding.

Line of Enquiry (LoE6)– What helps or hinders accessing help and support.

16.4.13 The role of DA champions is acknowledged as part of wider communications and awareness raising such as 'DA posters' with QR codes behind the doors of bathrooms both in patient and staff areas. There is also overt information on domestic abuse and safeguarding available within emergency departments including NIDAS cards, that is being expanded to outpatient areas.

16.4.14 NNUH is also working on mental health literature for display in public areas. This is due to be signed off at the Trust's board.

Line of Enquiry (LoE7) – Strategic Approach to Domestic Abuse – Male victims

16.4.13 The panel representative drew attention to another DARDR involving an elderly patient, that emphasised the need to avoid misconceptions about domestic abuse, and the need to recognise its occurrence across a breadth of demographics and relationships in the family unit. The representative's thoughts reflect a government policy paper "Supporting male victims" that said, *'Harmful stereotyping, combined with popular myths and misconceptions around male victims, can act as additional barriers when it comes to reporting and seeking help'.*[49] The representative also cited the Domestic Abuse Act, and recognising children as victims, the observation being that domestic abuse is recognised as affecting people of different ages and demographics, men, and women.

16.4.14 The trust also highlighted having begun work to become a trauma-informed organisation. This work driven by the Complex Health Hub, Human resources, and Chaplaincy, includes but is not limited to, evaluating our hospital support services, links to local support services, reviewing the language used in policies and a general culture shift via training with regards to how we identify trauma and how we manage it. This pertinent to male victims of domestic abuse, and the observations of this review will inform the development of that work.

[49] Source: Supporting male victims (accessible) - GOV.UK (www.gov.uk) (Accessed August 2023)

Line of Enquiry (LoE8) – Impact of Covid

16.4.14 There does not appear to have been any overt adverse impact of Covid on Simon and his attendance/treatment by NNUH.

Line of Enquiry (LoE9) – Equalities

16.4.15 Comments at 16.3.34.

16.5 Counsellor for Simon

16.5.1 The counsellor for Simon asked not to be involved in the review. As a result, and without providing any detail of the particular review, the chair contacted the British Association for Counselling & Psychotherapy, had discussions via email and Teams with the Registrar and Head of Professional Standards. They outlined accreditation, ethical standards, and policies, that the chair has used as a basis for analysis.

16.5.2 The chair was provided with thirteen papers that BACP considered relevant to this review, including a series of Good Practice in Action (GPiA) guides such as: - safeguarding vulnerable adults, - working with suicidal clients, - suicide, - coroners courts inquests and confidentiality, - confidentiality and record keeping, - sharing records, - writing reports for courts, - working with domestic abuse, - working with risk, - suicide risk.

16.5.3 Whilst beyond the scope of this review to consider the guidance in depth, the chair has examined some of the guidance notes and by reference to the terms of reference key lines of enquiry has made the following observations.

Line of Enquiry (LOE2) – Risk Assessment for domestic abuse and suicide Ideation / self-harm
Line of Enquiry (LOE3) – Response to domestic abuse – suicide ideation/ self-harm issues
Line of Enquiry (LOE4) – Access to specialist agencies
Line of Enquiry (LoE5)– Policies, Procedures & training re domestic abuse

GPiA116: Working with domestic abuse within the counselling professions.

16.5.4 Whilst the guidance has a section on supporting victims, including recognising domestic abuse, it does not cross reference with QA116 from NICE guidelines. The guidance states 'If a practitioner suspects a client is a victim/survivor, it is vital to voice concerns and not wait for them to raise the issue. Speaking out and signposting a client to appropriate support have been shown to be lifesaving (DARDR Case Analysis, 2019)'. It continues with advice as to seeking advice from a supervisor. The guidance includes references to national organisations.

16.5.5 Whilst risk assessment is touched upon and the DASH checklist is referenced, suggesting it as useful for reading and to provide insight, it is arguable that guidance on domestic abuse would benefit from including and not referencing information sources about 'recognition and response', and help in informing what the level of risk may be.

16.5.6 Furthermore, under section 6 of the guidance 'Safeguarding' it says "Practitioners should be able to recognise increased risk to their client from a third party, or to a third party from their client. In these situations, there may be a responsibility to act, with or without the client's consent". It is suggested that the guidance could be strengthened by providing 'detail' about recognising domestic abuse, and practical tools as to what to do based upon a risk assessment.

16.5.7 In conversation, the chair learned that the guidance is due for revision in April 2024, and BACP has already agreed to look at incorporating QS116.

(LO6) Learning Opportunity: To improve the ability of BACP accredited counsellors to recognise domestic abuse. **Response:** BACP have agreed to incorporate QS116 signs of domestic abuse into guidance. *(Will be completed by 31.03.2024)*

GPiA 126: Suicide risk when working in the counselling professions.
GPiA 042: Working with suicidal clients in the counselling professions.
GPiA 030: Safeguarding vulnerable adults within the counselling professions.

16.5.8 An examination of all three sets of guidance found that domestic abuse does not feature within any of the guidance notes, though 'abuse' in general terms does feature. It may be argued that domestic abuse is at risk of systemic invisibility in the context of suicide. Research in relation to the links between suicide and domestic abuse has been discussed with BACP, and it has been agreed that this will be presented to those responsible for reviewing these policy guidance notes.

(LO7) Learning Opportunity: To clarify the links between domestic abuse and suicide in the BACP guidance notes. **Response**: BACP have agreed to ensure that guidance ensures that the links between domestic abuse and suicide are highlighted in relevant guidance notes. *(Will be completed by 31.03.2024)*

16.5.9 The guidance GPiA 042 contains useful information in respect of responding to suicide risk and developing a collaborative crisis (safety) plan. In other words, practical guidance, as opposed to referring the reader to other material.

Line of Enquiry (LoE9) – Equalities

GPiA116: Working with domestic abuse within the counselling professions.

16.5 Guidance notes are clear as to the breadth of communities and how those with protected characteristics may be affected.

Summary

16.5 Sight of these policies shines a light on the role of counsellors in dealing with individuals who may be living in an abusive relationship and/or who are suicidal. It seems to the chair and panel, that there are opportunities to elevate the status of domestic abuse within the counselling profession, providing guidance and support to accreditation agencies. The scope of this work is beyond the scope of this review.

(LO8) Learning Opportunity: To raise the status of domestic abuse and ensure that counsellors are equipped to recognise and respond to domestic abuse appropriately. ***Recommendation 3:*** The Home Office are to seek to raise the status of domestic abuse (DA), exploring the potential of regulating private counsellors to ensure that DA is specifically cited within training requirements, and policy to ensure counsellors are equipped to recognise and respond to domestic abuse.
Outputs/Outcomes: Accreditation agencies require counsellors to undertake minimum training in respect of domestic abuse, recognition and response, and that policies/guidance provide specific information about signs of domestic abuse, and policies are in accordance with current policies and national guidance

16.6 Counsellor for Thomas

16.6.1 This analysis is based upon an interview with Simon's counsellor and commences with observations about Simon.

- *Thomas sought counselling owing to Simon having described him as being a narcissist and wanting to understand himself.*
- *They described Thomas as being a very self-sufficient, stoic character, and in some respects old-fashioned, keeping his emotions and real self hidden. She said that he*

had described himself as being introverted, and she thought he would keep his emotions hidden.

- *They linked his keeping matters hidden, to the fact of his sexual orientation, and how difficult this had been to 'come out,' as a married man with children. He had kept it secret for a long time.*
- *On exploring the break-up of the relationship with Simon, she thought Thomas had seen that as a failure and should have managed the situation better. She expressed an opinion that she did not see him as a controlling type of character. Simon had been candid about previous threats of divorce, and that he had been upset, wanting the marriage to work, and not giving up.*
- *They had explored his feelings, and capacity for empathy and had been provided evidence by way of examples including Thomas regularly visiting a female friend whose husband had passed away, and his having a number of dogs suggesting attachment.*
- *Asked about anxiety or depression, she had not observed this, and mused she could not think of anything that would upset him, as he would not let it.*

Lines of enquiry

16.6.2 Whilst the counsellor is no longer accredited, she had been with UKPC having been in practice for many years.

16.6.3 Upon exploring relevant training in respect of Safeguarding and Domestic Abuse, she replied she hadn't done specific training in respect of either.

16.6.4 The UKPC Standards of Education and Training (2017) includes a section on general principals and a sub-section on safeguarding that states; - must include developing an awareness of safeguarding issues in relation to clients and those likely to be impacted by the client's actions/inactions; - students must be equipped to understand their responsibilities in relation to relevant and up-to-date safeguarding legislation; - Trainings must ensure that they equip students to work in particular settings and to understand how to ensure compliance with safeguarding rules in accordance with that setting.[50]

16.6.5 In interview, there were no signs or concerns in respect of domestic abuse, or self-harm, in terms of Thomas her client or Simon, and therefore no need to consider any alert or need to inform/work with another agency.

16.6.6 Had there been signs, she was aware of responsibilities and exceptions to confidentiality. However, it is acknowledged that this area is complex and subject to a 'Code of Ethics and Professional Practice'.

16.6.7 In Thomas's case there was no need to breach confidentiality, and/or work with other agencies.

16.6.8 To the extent that the counsellor didn't recall specific safeguarding and domestic abuse training, it would seem that there is an opportunity to raise the status of domestic abuse and safeguarding.

16.6.9 The chair followed up with the Regulation and Quality Assurance Manager of UKPC outside the panel and was provided with a copy of "UKCP Standards of Education and Training". A relevant section states the following points, but does not within these points or elsewhere reference domestic abuse;

- The curriculum must include developing an awareness of safeguarding issues in relation to clients and those likely to be impacted by the client's actions/inactions.
- Students must be equipped to understand their responsibilities in relation to relevant and up-to-date safeguarding legislation.

[50] Source: ukcp-adult-standards-of-education-and-training-2017.pdf (psychotherapy.org.uk) (Accessed June 2023)

- Training must ensure that they equip students to work in particular settings and to understand how to ensure compliance with safeguarding rules in accordance with that setting.

16.6.10 The continuing professional development policies outside of working with children and young people, do not stipulate specifically safeguarding training, simply recommending a variety of professional development in relation to their client work, such as workshops, conferences, short courses or etc. In relation to children and young people, it's to renew their training every 3 years, and this is checked via our 5 yearly reaccreditation process. Registrants are expected to meet safeguarding and other legal training requirements as part of their CPD, and as declared when they renew each year that they are meeting Code of Ethics and Practice requirements.

16.6.11 There is no reference to domestic abuse, suggesting an opportunity to raise the status of domestic abuse, and ensure that counsellors are equipped to recognise and respond to domestic abuse appropriately.

16.6.12 The chair was similarly provided with a copy of "UKCP Code of Ethics and Professional Practice" and the QA manager highlighted the following paragraphs;

- *33. Maintain an awareness of, and comply with, all legal and professional obligations and UKCP polices which apply to your practice.*
- *35. Safeguard children and vulnerable adults, recognising your legal responsibilities concerning their rights and taking appropriate action should you consider any such person is at risk of harm.*
- *36. Ensure that you are familiar with and understand UKCP's published policies and guidance, in particular those on Safeguarding and on the Memorandum of Understanding on Conversion Therapy.*

16.6.11 There is no reference to domestic abuse within the code of ethic or training, that similar to BCPA suggests an opportunity to raise the status of domestic abuse and ensure that counsellors are equipped to recognise and respond to domestic abuse appropriately.

(LO8) Learning Opportunity: To raise the status of domestic abuse and ensure that counsellors are equipped to recognise and respond to domestic abuse appropriately. ***Recommendation 3:*** The Home Office are to seek to raise the status of domestic abuse (DA), exploring the potential of regulating private counsellors to ensure that DA is specifically cited within training requirements, and policy to ensure counsellors are equipped to recognise and respond to domestic abuse.
Outputs/Outcomes: Accreditation agencies require counsellors to undertake minimum training in respect of domestic abuse, recognition and response, and that policies/guidance provide specific information about signs of domestic abuse, and policies are in accordance with current policies and national guidance.

16.7 Family and Friends

16.7.1 On considering the accounts of family, it is clear they hold Thomas accountable for Simon taking his life. Their descriptions of the relationship describe Simon trapped in a marriage that he no longer wanted, along with accounts of Simon not being allowed to sleep and in effect being forced to sleep in his car, or elsewhere. They further described how Thomas appeared to dictate to Simon how to do things, that made them feel very uncomfortable. It seemed to them that Simon was fearful of losing everything, owing to the financial ties between them, a sense that was exacerbated when Thomas refused to proceed with a divorce for a long period of time.

16.7.2 The review acknowledges that his marriage tied him to Thomas emotionally and financially, therefore to an extent any refusal to divorce could be considered as maintaining control and influence over him. Statutory guidance in respect of coercion and control published in May

2023[51] is helpful in this regard, stating that 'the pattern of behaviour has to have a serious effect on the victim to either fear that:

- Violence will be used against them on two or more occasions (section 76 (4)(a)); and/or.
- Caused serious alarm or distress which has had a substantial adverse effect on the victim's usual day-to-day activities (section 76 (4) (b)).

16.7.3 Conversely, friends described an opposing view, in that Simon had been the person in charge.

16.7.4 The police have investigated the matters alleged and a decision was made to take no further action.

16.7.5 On enquiring about support, his sister Margaret had advised him to seek help from the police, but he had said that they would not listen to him as a gay male victim of domestic abuse. Her view was that had it been a heterosexual man, then perhaps they would have listened. This in part reflects the recognition by the DA Commissioner (Noted at 16.2.13) that men face additional barriers when disclosing domestic abuse. The panel were informed that the local police domestic abuse policy has been updated about possible domestic abuse occurring in relationships irrespective of gender or sexuality and now contains details of charities supporting LGBTQIA+ communities.

16.7.6 A government report on male victims also stated, "The year ending March 2018 CSEW showed that only just over half of male victims of partner abuse (50.8%) reported telling anyone personally about abuse experienced in the previous year. This compares to the 81.3% of female victims".[52] This report also acknowledges that Male victims with protected characteristics may be at greater risk of facing barriers to reporting and seeking help.

16.7.7 Safelives on exploring 'Barriers to accessing services for LGBT+ victims and survivors reported "While there are universal barriers to accessing specialist services, LGBT+ people can face additional challenges which are different to those experienced by heterosexual, cis women, and men. Existing evidence as well as our own experience suggests that LGBT+ people face a range of distinct barriers on a personal and systemic level, which often prevent them from getting the support they need. Personal barriers most often relate to LGBT+ people's perception of self and the abuse and their perception of the support system. In contrast, systemic barriers relate to the way services are designed and delivered that may result in them being less accessible and inclusive for LGBT people'[53].

16.7.8 The family testimony and research remind agencies of the continued need to (a) ensure support and awareness of the support available to gay male survivors of domestic abuse (b) recognise the barriers confronting gay male victims of domestic abuse and (c) continually assess the needs of gay males (See learning opportunity (LO1)), whilst acknowledging the work being undertaken in this regard. (See 16.2.21)

(LO9) Learning opportunity: The continued need to ensure support and awareness of support to gay male survivors of domestic abuse.

Response: - From April 2023, there is a local men's specialist IDVA and an LGBTQIA+ specialist, - Local police policy changes to emphasise that domestic abuse occurs in relationships irrespective of gender or sexuality, - Local police now have access to a male independent sexual violence advocate

16.7.9 Notwithstanding the above, one friend had advised Simon to seek help about his feelings, and it is a matter of fact that he did see a private counsellor, though she has declined to take part in the review.

[51] Source: Controlling or coercive behaviour: statutory guidance framework (accessible) - GOV.UK (www.gov.uk) (Accessed June 2023)
[52] Source: Supporting male victims (accessible) - GOV.UK (www.gov.uk) (Accessed June 2023)
[53] Source: Barriers to accessing services for LGBT+ victims and survivors | Safe lives (Accessed June 2023)

16.7.10 Whilst it is apparent that family (Sister and Aunt) have differing views to friends, there are consistencies. They would all agree that Simon was an immensely generous and caring man, who was passionate about his business and the care industry. It is also apparent, that Thomas was not able to demonstrate support/affection in the way that Simon wanted. One friend reflected '*Thomas was a very down to earth Norfolk person'* and continued, '*On further reflection perhaps couldn't give Simon that type of support'*. And on considering Thomas's response to two bereavements, she wrote in her police statement that Thomas had not come to support Simon at the funeral of a nephew, and whose support was found wanting when Simon's father was unwell and then passed away. The panel acknowledge that the descriptions of behaviour by family and friends are value based but are important as they provide perspective to this review.

16.7.11 As a further reflection, Simon's family expressed disappointment that his counsellor had not engaged with the process and have asked that in relation to Recommendation 3, they consider whether regulations regarding counselling services place a more formal obligation to take part in statutory reviews.

17. CONCLUSIONS AND LESSONS LEARNED

17.1 Conclusions

17.1.1 The chair and panel are mindful of 'Hindsight Bias' and have sought to view the circumstances leading up to Simon's death as broadly as possible, to understand the circumstances of Simon's life from his perspective to help explain his death. Finally, the panel is grateful to family and friends who have shone a light on the relationship between Simon and Thomas.

17.1.2 Simon was a man who had lived with problems related to his mental and physical health for many years, in 2005 having been diagnosed with bipolar affective disorder, a mental health condition which causes a person's mood to swing from one extreme to the other, and in 2008 with chronic fatigue syndrome (a long-term condition causing multiple physical and psychological symptoms including extreme tiredness, sleep and memory problems, dizziness, headaches, muscle, and joint aches).

17.1.3 It is apparent from the note he left; he was convinced that he had a grave illness, referencing these concerns, referring to pain in his abdomen, and pain behind his right eye and base of his skull.

17.1.4 Whilst bipolar is not curable and is a lifelong condition, the agency records do not show any concerns in this regard during the relevant period. However, Thomas describes 'huge mood swings that were difficult to manage,' and a friend described outbursts of anger at work. It is therefore possible that the true extent of a deterioration in his mental health was not known, and unfortunately the counsellor who may provide further insight has declined to take part in this review.

17.1.5 There was a history of attempts to take his own life, in the 2000's, including 2004 an overdose that resulted in his admission to hospital under the Mental Health Act. Further attempts were made in 2005 by carbon monoxide poisoning, and two attempts in 2006 through overdoses. The panel noted research (16.2.4) reporting previous attempts as a risk factor that did not diminish over time for those who take their own life.

17.1.6 It is clear from the testimony of everyone that he was a very generous character, who was keen to help others, which may explain the drive around his business that provided community care for people with complex health and social care needs.

17.1.7 Undoubtedly, he was impacted by the passing of his mother (2014), about whom he wrote in his suicide note, *"The only things I want in the world are my mum to hug me and tell me things will be okay".* The subsequent passing of his father (June 2021) and cousin (August

2021) around the anniversary of his mum's death added to his sense of loss and worries that were building in 2021.

17.1.8 Arguably Simon's losses, and closeness to his aunt Doris were a source of anxiety to him, in that he feared further bereavements, as illustrated by an excerpt from the note he left, " *To my dearest auntie 'Doris' (not real name) and uncle, I love you more than you will ever know and I know this will be so hard for you yes I am being very selfish I can't go through losing either let alone both of you*" and, "*All I am left with is more pain and trauma to come, and I've reached the end of my tolerance".* The chair is aware from conversations that his aunt spends considerable time caring for her husband.

17.1.9 Simon lived with other worries in addition to relationship problems with Thomas. In the last two years of his life, Simon had successfully wrestled with dependency on prescribed medication related to pain relief, the side-effects of which brought more pain, discomfort, and difficult symptoms to manage. In addition, he underwent tests for long-standing symptoms, for which no clear diagnosis ever resulted.

17.1.10 Proximate to when Simon took his own life it was established there was a director's loan against the company with a significant amount owed to HMRC. Of note, is the fact that he had previously had dealings with HMRC, when Simon had expressed suicidal ideation in 2015. The chair has been provided with a copy of an email associated with this suicidal ideation.

17.1.11 Whilst grieving, it is clear from the testimony of everyone, that the relationship between Simon and Thomas was in difficulty. It is a matter of fact that immediate family members made an allegation against Thomas of controlling and coercive behaviour, after Simon took his own life. The police concluded their investigations, and no further action resulted.

17.1.12 The chair has been able to speak to immediate family, and wider friends/associates. Whilst on the one hand family allege, controlling behaviour in the form of sleep deprivation, preventing Simon having access to his car and reportedly telling Simon what to do; on the other hand, friends described Simon having been the person in charge, with outbursts and a reported incident in the home that resulted in Thomas sustaining a small injury.

17.1.13 One theory as to why Simon had not approached police was that they would not listen to a man, and a view from the family member was that they may have, had he been a heterosexual man. Whilst recognising additional barriers facing the LGBTQIA+ community, it has not been possible to triangulate this theory in Simon's case, though the review highlighted the need to address these barriers.

17.1.14 One element of control that Thomas had over Simon related to the fact that Thomas would not cede to Simon's request for a divorce, refusing to sign divorce papers. Thomas acknowledges this fact, and this is cited within witness statements to the police. Undoubtedly their business venture also bound Simon and Thomas together financially, though there is no evidence to suggest that Thomas exerted financial control over Simon, as he was able to book holidays and travel freely, such as a trip to the Caribbean in the December before he took his life.

17.1.15 Whilst it has not been possible to identify a trail of abuse, speaking to family and friends does shine a light on the relationship, and Simon's needs. Simon wrote in his suicide note, *"Thomas if anything can be drawn from this is that you sit up and see what your behaviour does. I don't blame you as such. That would be childish. I have begged you to take care of me just a little bit. I love you so very dearly I would literally do anything for you. I get that you always do what is best for you and that if you ignore and pretend, you're not the problem that it means someone else will sort the problem."* One person described Simon, *"as the most loving person that any person could wish to have around."* Conversely, Thomas has been described as 'stoic' and undemonstrative. In some ways, it is arguable that Simon and Thomas's emotional needs were different, with Simon needing love in a more demonstrable

manner. This observation is supported by a friend of Thomas who on reflection (14.2.8) Thomas was not the sort of person who would give a hug.

17.1.16 Another layer of complexity apparent within the family unit were the children he and Thomas cared for. Undoubtedly accepting responsibility for the care of children with minimal notice would have been stressful and difficult to manage.

17.1.17 The review therefore recognises the concurrent nature of several stressors in Simon's life that are pertinent to him taking his life. It is not possible to conclude any one factor weighed more heavily on Simon's mind. These included:

- His worries regarding his physical health
- His mental health
- Financial worries
- Bereavement and fear of future bereavements
- Relationship problems with Thomas and the need for demonstrable support.

17.1.18 Simon's sister also referenced his mother's death. One study observed that" Bereavement following parental death experienced in adulthood may be associated with suicide over many years, but this risk has received scant attention."[54]

17.1.19 The review has also shone a light about domestic abuse within gay male relationships, in terms of higher rates of domestic abuse (See 11.6,11.8 &16.3.15), being less likely to know where to access support in rural communities as opposed to city environments (See 16.2.19). These are concluded as being important research that demonstrates the need for ongoing awareness raising that is being undertaken locally.

17.1.20 The panel also considered the intersection of other factors relevant to Simon such as; - rates of domestic abuse in LGBT communities' – rates of suicide in LGBT communities, - recent research linking suicide to impact of domestic abuse and finally any element of unconscious bias where domestic abuse is framed as a woman's issue. Whilst not concluding any impact, the panel recognises the importance of raising awareness of these factors in tackling domestic abuse.

(LO10) Learning Opportunity: The review identified the intersection of individual stressors as contributory factors in understanding Simon's death by suicide, together with broader universal factors such as suicide and domestic abuse rates in LGBTQIA+ communities necessitating awareness raising across professionals, and to be taken account of when conducting equalities impact assessments and devising future domestic abuse and suicide prevention strategies. **Recommendation 4:** Seek to raise awareness of the intersection of an individual's stressors (mental health, financial worries, bereavement) and wider factors (DA and suicide rates within LGBT communities & unconscious bias) across health professionals and local counselling services, that empowers those professionals to be able to recognize and respond appropriately to patients/clients.
Outputs/Outcome: Awareness raising across professionals**.** Contributing to increased referral rates to specialist domestic abuse service providers.

17.1.21 The panel reflected on (a) the role of private counselors who had been involved with Simon and Thomas and (b) the number of counselors in the Norfolk area, as an opportunity to further raise the status of domestic abuse within that profession locally and better integrate them into the systemic approach to tackling domestic abuse.[55]

[54] Source: Suicide Around the Anniversary of a Parent's Death in Sweden | Psychiatry and Behavioral Health | JAMA Network Open | JAMA Network (Accessed March 2024)

[55] A local register shows there are 294 registered counsellors in Norfolk. Counselling in Norfolk - Counselling Directory (counselling-directory.org.uk)

(LO11) Learning Opportunity: To recognise the pivotal role of private counsellors in recognising and responding appropriately to domestic abuse. **Recommendation 5:** NCSP are to develop a coordinated awareness raising campaign to domestic abuse across the county's counsellors ensuring they are equipped to recognise and respond appropriately to domestic abuse.
Outputs/Outcome: - All locally registered private counsellors are invited to receive a briefing on; - domestic abuse recognition & response; - local strategic approach to domestic abuse; - offers of ongoing involvement awareness raising and training, - Increased awareness across private counsellors, - Increased risk assessments and referrals to domestic abuse specialists

17.2 Lessons Learned

17.2.1 This review has benefitted from detailed chronologies, candid IMR's and open conversations with panel representatives and other professionals has helped inform the identification of 'learning opportunities' summarised at Appendix F.

Professional Curiosity, Recognition and Response (LO3, LO5, LO6, LO7)

17.2.2 Simon had contact with healthcare professionals and whilst he never raised concerns about domestic abuse, he was never asked about feelings of safety, nor did domestic abuse feature as part of routine screening. This was applicable to his GP practice and secondary care at the local hospital where he had a number of outpatient appointments.

17.2.3 Simon and Thomas both had contact with independent counsellors accredited by different agencies. The extent to which domestic abuse is referenced across each agency is different, one with more overt guidance, one more reliant on safeguarding guidance. In both cases there appears to be an opportunity to raise the status of domestic abuse, it links to suicide and adapt policies to reflect current understanding, statutory guidance as well as incorporated indicators of domestic abuse in accordance with QS116.

Counselling - National Accreditation Standards for Counselling Services (LO8)

17.2.4 The different approach by agencies that accredit private counsellors suggests that the status of domestic abuse would benefit from being elevated and subject to national standards for professionals who through counselling practice are likely to meet clients living with domestic abuse.

17.2.5 The number of private counsellors working in Norfolk provides an opportunity to integrate them into the systemic approach to tackling domestic abuse.

Equalities and Intersectionality (LO1, LO2, LO9, LO10)

17.2.6 The review shone a light on barriers facing gay men in seeking help through research cited within the report and also through the testimony of Simon's sister who reported that he had said police would more likely have believed him, if he were a heterosexual male, reinforcing a need to raise awareness of domestic abuse in gay male relationships.

17.2.7 The intersection of sexuality and gender is relevant in this case as when his sister had told him that he should speak to the police, his response suggested he would not be believed because he was gay. The panel recognised from the breadth of research the intersection of domestic abuse and suicide rates in the gay community, as well as other relevant research about accessing support in rural communities.

17.2.8 The review acknowledges the commissioning of specialist male and LGBTQIA+ advocacy services locally as good practice but highlights the importance of completing an equalities impact needs assessment and associated action plan for future iterations of domestic abuse strategies.

17.3 Good Practice Identified and Significant Developments

This review has identified several areas of good practice that are summarised here:

GP

17.3.1 Simon benefited from seeing the same GP over a period of time, and this is acknowledged as good practice.

17.3.2 There was good partnership working between the GP and CGL in facilitating a conversation between CGL and Simon

NNUH

17.3.3 Role of DA champions in hospital is recognised as good practice.

Service Provision

17.3.3 The provision of a specialist male IDVA and an LGBTQIA+ IDVA are recognised as good practice. From April 2024, two Health IDVAs provided by NIDAS and based within the Norfolk and Norfolk and Norwich University Hospital and the Queen Elizabeth Hospital, Kings Lynn. This compliments the Health IDVA already in place at the James Paget Hospital. Since this report was submitted to the Home Office for quality assurance, the health based IDVAs at NNUH and QEH are no longer in position.

Information provision

17.3.4 The development of bespoke information for LGBTQIA+ communities is welcomed.

18. RECOMMENDATIONS

18.1 Local Recommendations

18.1.1 IMR authors identified recommendations that should be implemented internally. If an agency is not listed, then no recommendations were made.

GP

- To raise GP awareness of NICE guidance and Faculty of Pain Medicine guidance on supporting people who wish to withdraw from methadone and other opioids including regular review and recognising the withdrawal symptoms and how to enquire about these.
- To raise GP awareness of the existence of intimate partner violence among lesbian and gay couples and its incidence can be higher than that among heterosexual couples.

18.2 Panel recommendations

18.2.1 It is recognised that Recommendations 4 and 6 are complimentary. The panel agrees it is important that each recommendation is retained to ensure the focus of learning is clear.

R1	**Recommendation 1**: NCSP to ensure that an EINA and action plan is completed in relation to future Domestic abuse strategies.	NCSP
R2	**Recommendation 2:** Update the template DA policy, bringing it up to date with changes in legislation, so as to encourage professionals to recognise indicators of, and routinely ask about domestic abuse.	GP/ICB
R3	***Recommendation 3:*** The Home Office are to seek to raise the status of domestic abuse (DA), exploring the potential of regulating private counsellors to ensure that DA is specifically cited within training requirements, and policy to ensure counsellors are equipped to recognise and respond to domestic abuse. *And in so doing consider the role of regulated counsellors taking part in statutory reviews.*	Home Office
R4	**Recommendation 4:** Seek to raise awareness of the intersection of an individual's stressors (mental health, financial worries, bereavement) and wider factors (DA and suicide rates within LGBT communities & unconscious bias) across health professionals and local counselling services, that empowers those professionals to be able to recognise and respond appropriately to patients/clients.	NCSP
R5	**Recommendation 5:** NCSP are to develop a coordinated awareness raising campaign to domestic abuse across the county's counsellors ensuring they are equipped to recognise and respond appropriately to domestic abuse.	NCSP
R6	**Recommendation 6:** The learning from this review is shared across the partnership to raise awareness of domestic abuse, links to suicide, risk of intersectionality for gay male victims and all the learning opportunities raised.	NCSP

APPENDIX A

Domestic Abuse Related Death Review Terms of Reference: Case of Simon

This Domestic Abuse Related Death Review (DARDR) is being completed to consider agency involvement with **Simon and Thomas** following the death of **Simon in January 2022**. The DARDR is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose of a DARDR

1. To review the involvement of each individual agency, statutory and non-statutory, with **Simon and Thomas** during the relevant period of **January 2019 to January 2022.**
2. To summarise agency involvement prior to **January 2019.**
3. To establish what lessons are to be learned regarding the way in which local professionals and organisations work individually and together to safeguard victims.
4. To identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
5. To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
6. To prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
7. To contribute to a better understanding of the nature of domestic violence and abuse.
8. Identify good practice.

Key Lines of Inquiry

J. Analyse the **communication and co-operation** which took place within and between agencies regarding Simon.

K. Analyse the opportunity for agencies to identify and **assess risk of domestic abuse** or **suicide ideation/self-harm**, including what would have enabled or hindered disclosure.

L. Analyse agency **responses to any identification of domestic abuse or suicide ideation/self-harm.**

M. Analyse organisations' **access to specialist domestic abuse agencies**.

N. Analyse the **policies, procedures, and training** available to the agencies involved, with regard to domestic abuse, self-harm/suicidal ideation.

O. Analyse any evidence of **seeking help**, as well as considering what might have **helped or hindered access to help and support**. *(That includes what barriers there were to Simon, Thomas, friends, and family seeking help)*

P. Explore the **strategic approach to domestic abuse in respect of male victims** and those in same sex relationships.

Q. The extent to which **Covid-19** effected agency involvement with Simon.

R. **Equalities**: The Review Panel will consider all protected characteristics as noted at paragraph 13.

Role of the DARDR Panel, Independent Chair and the CSP

9. The Independent Chair of the DARDR will:
   a) Chair the Domestic Homicide Review Panel.
   b) Co-ordinate the review process.
   c) Quality assures the approach and challenge agencies where necessary.
   d) Produce the Overview Report, Executive Summary and collate action plan by critically analysing each agency involvement in the context of the established terms of reference.

10. The Review Panel:
   a) Agree robust terms of reference incorporating those terms of reference that wish to be included by family and friends of the victim.
   b) Ensure appropriate representation of your agency at the panel: panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
   c) Prepare Individual Management Reviews (IMRs) and chronologies through delegation to an appropriate person in the agency.
   d) Discuss key findings from the IMRs and invite the author of the IMR (if different) to the IMR meeting.
   e) Agree and promptly act on recommendations in the IMR Action Plan.
   f) Ensure that the information contributed by your organisation is fully and fairly represented in the Overview Report.
   g) Ensure that the Overview Report is of a sufficiently high standard for it to be submitted to the Home Office, for example:
      - The purpose of the review has been met as set out in the ToR;
      - The report provides an accurate description of the circumstances surrounding the case; and
      - The analysis builds on the work of the IMRs, and the findings can be substantiated.
   h) To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
   i) On completion present the full report to the Community Safety Partnership.
   j) Implement your agency's actions from the Overview Report Action Plan.

Norfolk Community Safety Partnership working with the DARDR Chair:

   a) Submit the Executive Summary, Overview Report and Action Plan to the Home Office Quality Assurance Panel.
   b) Working with the Chair of the DARDR forward Home Office feedback to the family, Review Panel and NCSP.
   c) Agree publication date and method of the Executive Summary and Overview Report.
   d) Notify the family, Review Panel and NCSP of publication date.

Definitions: Domestic Violence and Coercive Control

11. The Overview Report will make reference to the term's domestic violence and coercive control. The Review Panel understands and agrees to the use of the cross-government definition (amended March 2013) as a framework for understanding the domestic violence experienced by the victim in this DARDR. The cross-government definition states that domestic violence and abuse is:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence, or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.
Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."
This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group."

12. The overview report will make reference to the term domestic abuse and the statutory definition as per the Domestic Abuse Act.

(1) This section defines "**domestic abuse**" for the purposes of this Act.

(2) Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—

(a) **A and B** are each **aged 16 or over** and are **personally connected** to each other, and

(b) the behaviour is abusive.

(3) Behaviour is **"abusive"** if it consists of any of the following—
(a) physical or sexual abuse;
(b) violent or threatening behaviour;
(c) controlling or coercive behaviour;
(d) economic abuse (see subsection (4));
(e) psychological, emotional, or other abuse;

and it does not matter whether the behaviour consists of a single incident or a course of conduct.

(4) "**Economic abuse**" means any behaviour that has a substantial adverse effect on B's ability to—
(a) acquire, use, or maintain money or other property, or
(b) obtain goods or services.

(5) For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

Equality and Diversity

13. The Review Panel will consider all protected characteristics (as defined by the Equality Act 2010) of both **Simon and Thomas** (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation) and will also identify any additional vulnerabilities to consider.

Parallel Reviews

14. Coronial proceedings continue in parallel. The inquest is scheduled for the 15th December 2021 and the coroner's officer has been appraised of this review.

Membership

15. It is critical to the effectiveness of the meeting and the DARDR that the correct management representatives attend the panel meetings. Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.

16. The following agencies are to be on the Review Panel:
    - Norfolk and Norwich University Hospital
    - Office of the Police and Crime Commissioner for Norfolk
    - Norfolk County Council – Norfolk Public Health
    - Integrated Care Board
    - Norfolk Constabulary
    - Old Mill Surgery
    - Norwich City Council
    - Mankind Initiative
    - Change, Grow, Live
    - Leeway Domestic Violence and Abuse Services
    - Norfolk and Suffolk Foundation Trust

DARDR Chair Role and the Panel

17. **Mark Wolski** has been commissioned by NCSP to independently chair this DARDR. His contact details will be provided to the panel, and you can contact them for advice and support during this review.

Collating information to support the review.

18. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted and secure all relevant records.

19. Chronologies, Individual Management Review (IMRs) or factual reports will be completed by the following organisations known to have had contact with **Simon and Thomas** during the relevant time period:

Norfolk and Norwich University Hospital
Integrated Care Board
Norfolk Constabulary
Old Mill Surgery
Norwich City Council
Change, Grow, Live

20. Each IMR will:
    - Set out the facts of their involvement with **Simon and Thomas**
    - Critically analyse the service they provided in line with the specific terms of reference;
    - Identify any recommendations for practice or policy in relation to their agency;
    - Consider issues of agency activity in other areas and review the impact in this specific case.

Development of an action plan

21. Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs with clear owners and completion dates of those actions. The Overview Report will make clear that agencies should report to NCSP on their action plans within 3 months of the Review being completed.

Liaison with the victim's family and [alleged] perpetrator and other informal networks

22. The review will sensitively attempt to involve the **family of Simon** in the review once it is appropriate to do so in the context of on-going criminal proceedings. The chair will lead on family engagement.

23. **Simon's partner Thomas** will be invited to participate in the review.

24. Family liaison will be coordinated in such a way as to aim to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.

25. The Review Panel discussed involvement of other informal networks of the **Simon and Thomas** and will consider such involvement as the review progresses.

Media handling

26. Any enquiries from the media and family should be forwarded to NCSP who will liaise with the chair and associated agencies communications leads. Panel members are asked not to comment if requested. The

NCSP and its Chair will make no comment apart from stating that a review is underway and will report in due course.

27. The NCSP are responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

28. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

29. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DARDR and for the secure retention and disposal of that information in a confidential manner.

30. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Documents will be password protected.

31. If an agency representative does not have a secure email address, then their non-secure address can be used but all confidential information must be sent in a password protected attachment. The password used must be sent in a separate email.

32. If you are sending password protected document to a non-secure email address, it must be a recognisable work email address for the professional receiving information. Information from DARDR should not be sent to a gmail / hotmail or other personal email account unless in rare cases when it has been verified as the work address for an individual or charity.

33. No confidential content should be in the body of an email to a non-secure email account. That includes names, DOBs and address of any subjects discussed at DARDR.

Disclosure

34. Disclosure of facts or sensitive information will be managed and appropriately so that problems do not arise. The review process will seek to complete its work in a timely fashion in order to safeguard others.

35. The sharing of information by agencies in relation to their contact with the victim and/or the alleged perpetrator is guided by the following:
    a) The Data Protection Act 1998 governs the protection of personal data of living persons and places obligations on public authorities to follow 'data protection principles'.

b) The 2016 Home Office Multi-Agency Guidance for the Conduct of DARDRs (Guidance) Section 10 outlines data protection issues in relation to DARDRs (Par 98).

c) Data Protection Act and Living Persons: The Guidance notes that in the case of a living person, for example the perpetrator, the obligations do apply. However, it further advises in Par 99 that the Department of Health encourages clinicians and health professionals to cooperate with domestic homicide reviews and disclose all relevant information about the victim and where appropriate, the individual who caused their death unless exceptional circumstances apply.

d) Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:
    - The review team should be informed about the existence of information relevant to an inquiry in all cases; and
    - The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or
    - partial redaction of record content.

e) Human Rights Act: information shared for the purpose of preventing crime (domestic abuse and domestic homicide), improving public safety, and protecting the rights or freedoms of others (domestic abuse victims).

f) Common Law Duty of Confidentiality outlines that where information is held in confidence, the consent of the individual should normally be sought prior to any information being disclosed, with the exception of the following relevant situations – where they can be demonstrated:
    i) It is needed to prevent serious crime.
    ii) there is a public interest (e.g., prevention of crime, protection of vulnerable persons)

APPENDIX B – CONTACT WITH FAMILY

Date and time of contact (or attempt)	Communication between		Mode of contact	Outcome of contact
12/04/2022	CSP	Friend	Letter	Initial contact
12/04/2022	CSP	Sister	Letter	Initial contact
14/04/2022	CSP	Partner	Letter	Initial contact
14/04/2022	Partner	Chair	Email	Initial contact
24/04/2022	Chair	Friend	Letter	Initial contact
24/04/2022	Chair	Sister	Letter	Initial contact
24/04/2022	Chair	Partner	Email	Initial contact
25/04/2022	Partner	Chair	Email	Information provided
27/04/2022	Chair	Partner	Email	Follow up
06/05/2022	Chair	Partner	Tel Call	Initial discussion and explanation
06/05/2022	Partner	Chair	emails	Information and consent provided
09/05/2022	Chair	Partner	Email	Arrange meeting
17/05/2022	Chair	Friend	Tel call	Would like to engage. (subsequently withdrew)
25/05/2022	Chair	Sister	Tel Call	Declined to be involved
17/06/2022	Chair	Friend	Email	Arrange meeting
28/09/2022	Chair	Partner	Email	Update
12/11/2022	Chair	Aunt	Email x 2	Arrange meeting (subsequently withdrew)
12/11/2022	Chair	Aunt	Tel. meeting	Account provided
22.11.2022	Chair	Sister	Emails x 3	Regarding involvement in DARDR process
05.12.2022	Chair	Sister	Emails x 3	Arrange meeting
08.12.2022	Chair	Sister	Texts	Tel meeting cancelled
23.12.2022	Chair	Sister	Email x 2	Arrange meeting New Year
06/01/2023	Chair	Sister	Tel. meeting	Account provided
13/01/2023	Chair	Stepson	Tel. meeting	Does not want to be involved
24/01/2023	Partner	Chair	Email	Update request
01/02/2023	Chair	Stepson	Tel. call	Brief details, declined to take part in review
02/02/2023	Chair	Partner	Email	Update provided. Rational provided.
10/02/2023	Chair	Friend of S & T	Email x 2	Initial contact (subsequent meeting took place)
10/02/2023	Chair	Friend of S & T	Email x 2	Initial contact (subsequent meeting took place)
05/03/2023	Chair	Sister	Email x 2	Information request re coroner. Update given
27/03/2023	Chair	Sister	Tel call	Spoke about review and family. She knows that stepson doesn't want to be involved.
27/03/2023	Chair	Sister	Email x 2	Request and permission regarding statement release
11/04/2023	AAFDA	Chair	Email	Permission to release statement
21/04/2023	Chair	Aunt	Phone call	Arrange meeting with AAFDA. Subsequently aunt withdrew from process and had informed AAFDA who told chair.
25/04/2023	Chair	Partner	Email	Arranging meeting
08/05/2023	Chair	Partner	Email	Arranging meeting

20/05/2023	Chair	Partner	Email	Arranging meeting (Note date had to be cancelled twice)
09/06/2023	Chair	Partner	Email	Arranging meeting
12/06/2023	Chair	Partner	Email	Arranging meeting
12/06/2023	Chair	Aunt	Text x 2	Aunt withdraw from review process. There are a number of other emails between Chair and AAFDA prior to this date.
14/06/2023	Chair	Partner	Email	Arranging meeting
17/06/2023	Chair	Partner	Tel call	
17/06/2023	Partner	Chair	3 emails	Information and consent provided
27/09/2023	Chair	Partner	2 emails	Brief update
09/12/2023	Chair	Sister	Email	Update of proposal to share precis/Response
09/12/2023	Chair	Aunt	Email	Update of proposal to share precis. /No response
09/12/2023	Chair	Partner	Email	Update of proposal to share precis/Response
14/12/2023	Chair	Sister	Tel. call	Update of proposal to share precis
15/12/2023	Chair	Sister	Email	Precis shared
16/12/2023	Chair	Partner	Email	Precis shared
16/12/2023	Chair	Aunt	Email	Confirm receipt email 9th and offer precis. Also reminded of AAFDA as having previously been supported.
18/12/2023	Chair	Partner	Email	Amendments to report
18/12/2023	Chair	Sister	Email	Amendments to report
19/12/2023	Chair	Aunt	Email	Sharing of parts of report
04/01/2024	Chair	Aunt	Email	Amendments to report
02/02/2024	Chair	Partner	Email/calls	Amendments to report & clarification
03/02/2024	Chair	Sister/Aunt	Email	To arrange sharing full report
03/03/2024	Chair	Sister/Aunt	Meeting	Shared draft report
15/03/2024	Chair	Partner	Emails	Several emails to schedule meeting
31/03/2024	Chair	Partner	Meeting	Shared draft report

APPENDIX C - Independence statement

Chair of Panel

Mark Wolski was appointed by Norfolk Community Safety Partnership as Independent Chair of the DARDR Panel and is the author of the report.

He is a former Metropolitan police officer with 30 years operational service, retiring in February 2016. He served mainly as a uniformed officer, holding the role as Deputy Borough Commander at the Boroughs of Haringey, Harrow and at the Specialist Operations command of Aviation Security. During his service he gained significant experience leading the response to Domestic Abuse, Public Protection and Safeguarding.

Mark has subsequently acted as a consultant in the field of Community Safety, Independent Chair of a Marac Steering Group, strategic lead, and commissioner of VAWG services and as a DARDR chair/co-chair.

He has completed the Home Office DARDR training, AAFDA DARDR training, and undertaken the Foundation Course in the Social Institute of Excellence Learning Together systems model for case reviews. He has also undertaken the Home Office approved Offensive Weapons Homicide review training.

During and since his MPS service he has had no personal or operational involvement with Norfolk Community Safety Partnership.

APPENDIX D – Definition of Domestic Abuse

Section 1: Definition of "domestic abuse"
(1) This section defines "domestic abuse" for the purposes of this Act.
(2) Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if— (a) A and B are each aged 16 or over and are "personally connected" to each other, and (b) the behaviour is abusive.
(3) Behaviour is "abusive" if it consists of any of the following— (a) physical or sexual abuse; (b) violent or threatening behaviour; (c) controlling or coercive behaviour; (d) economic abuse (see subsection(4)); (e) psychological, emotional, or other abuse; and it does not matter whether the behaviour consists of a single incident or a course of conduct.
(4) "Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to — (a) acquire, use, or maintain money or other property, or (b) obtain goods or services.
(5) For the purposes of this Act, A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).
(6) References in this Act to being abusive towards another person are to be read in accordance with this section.
(7) For the meaning of "personally connected", see section 2.

Section 2: Definition of "personally connected"
(1) Two people are "personally connected" to each other if any of the following applies — (a) they are, or have been, married to each other; (b) they are, or have been, civil partners of each other; (c) they have agreed to marry one another (whether or not the agreement has been terminated); Domestic Abuse Act 2021 Statutory Guidance 22 (d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated); (e) they are, or have been, in an intimate personal relationship with each other; (f) they each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2)); (g) they are relatives.
(2) For the purposes of subsection (1)(f) a person has a parental relationship in relation to a child if — (a) the person is a parent of the child, or; (b) the person has parental responsibility for the child.
(3) In this section — "child" means a person under the age of 18 years; "civil partnership agreement" has the meaning given by section 73 of the Civil Partnership Act 2004; "parental responsibility" has the same meaning as in the Children Act 1989; "relative" has the meaning given by section 63(1) of the Family Law Act 1996

Section 3: Children as victims of domestic abuse
(1) This section applies where behaviour of a person ("A") towards another person ("B") is domestic abuse.
(2) Any reference in this Act to a victim of domestic abuse includes a reference to a child who – (a) sees or hears, or experiences the effect of, the abuse, and (b) is related to A or B.
(3) A child is related to a person for the purposes of subsection (2) if – (a) the person is a parent of, or has parental responsibility for, the child, or (b) the child and the person are relatives.
(4) In this section – "child" means person under the age of 18 years; "parental responsibility" has the same meaning as in the Children Act 1989 (see section 3 of that Act); "relative" has the meaning given by section 63(1) of the Family Law Act 1996.

APPENDIX E - LGBTQIA+ Local Information Examples

LGB-DA.pdf (norfolklgbtproject.org.uk)

Trans-DA.pdf (norfolklgbtproject.org.uk)

APPENDIX F - Learning opportunities summary

Learning Opportunity	R.'tion Y/N	Agency R.'tion or Response	Agency
Learning opportunity (LO1): NCSP ensure that Equalities Impact Needs Assessments are routinely completed, with an associated action plan that ensures that needs of diverse groups (in this case, men) are identified and acted upon.	**Y (R1)**	**n/a**	**Norfolk County Council**
Learning Opportunity (LO2): To raise awareness of rates of intimate partner violence among LGBTQIA+ communities.	**n/a**	**Y**	**ICB / GP practice**
Learning Opportunity (LO3): To ensure that local GP domestic abuse policies are updated in accordance with recent changes in legislation, guidance, and research regarding enquiry about domestic abuse.	**Y (R2)**	**N**	**ICB / GP practice**
(LO4) Learning Opportunity: Ensuring patients who are reducing dependency on methadone, are assessed every two weeks.	**n/a**	**Y**	**ICB / GP practice**
(LO5) Learning Opportunity: To improve professional curiosity of professionals through recognition of possible indicators of domestic abuse.	**N**	**Y**	**NNUH**
(LO6) Learning Opportunity: To improve the ability of counsellors to recognise domestic abuse.	**N**	**N**	**BACP**
(LO7) Learning Opportunity: To clarify the links between domestic abuse and suicide in the BACP guidance notes.	**N**	**N**	**BACP**
(LO8) Learning Opportunity: To raise the status of domestic abuse and ensure that counsellors are equipped to recognise and respond to domestic abuse appropriately	**Y (R3)**	**N**	**Home Office**
(LO9) Learning opportunity: The continued need to ensure support and awareness of support to gay male survivors of domestic abuse.	**N**	**N**	**n/a**
(LO10) Learning Opportunity: The review identified the intersection of individual stressors as contributory factors in understanding Simon's death by suicide, together with broader universal factors such as suicide and domestic abuse rates in LGBTQIA+ communities necessitating awareness raising across professionals, and to be taken account of when conducting equalities impact assessments and devising future domestic abuse and suicide prevention strategies.	**Y (R4)**	**N**	**NCSP**
(LO11) Learning Opportunity: To recognise the pivotal role of private counsellors in recognising and responding appropriately to domestic abuse.	**Y (R5)**	**N**	**NCSP**

APPENDIX G – DARDR ACTION PLAN

Recommendation	Scope	Action to take	Lead Agency	Key Milestones achieved	Target Dates	Date of completion and outcome
Recommendation 1: NCSP to ensure that an EINA and action plan is completed in relation to future Domestic abuse strategies.	Local	NCSP to undertake EIA of current partnership domestic abuse strategy. Developing process to ensure that all partnership strategies are subject to an Equality Impact Assessment.	NCSP	EIA completed. Process completed.	January 2024 April 2024	
Recommendation 2: Update the template DA policy for GPs, bringing it up to date with changes in legislation, so as to encourage professionals to recognise indicators of, and routinely ask about domestic abuse.	Local	Domestic violence and abuse template policy for general practice to be updated and shared to highlight consideration is given to implementing the use of safe routine enquiry in particular if someone presents with indicators of possible domestic violence or abuse (NICE Quality Standard 116) and highlighting that The Domestic Abuse Bill 2021 has emphasised routine enquiry is already in place in maternity and mental health services.	ICB(GP)	Review of NICE Quality Standard 116 and Domestic Abuse Bill 2021 and update of Domestic Violence and Abuse template policy for general practice	December 2023	December 2023 Greater awareness that consideration is given to routine enquiry in general practice.
Recommendation 3: The Home Office are to seek to raise the status of domestic abuse (DA), exploring the potential of regulating private counsellors to ensure that DA is specifically cited within training requirements, and policy to ensure counsellors are equipped to recognise and respond to domestic abuse.	National	Home Office are to work with the Domestic Abuse Commissioners Office to explore the steps required for introducing statutory regulation for counselling services. Home Office are to consider whether any statutory regulation could be incorporated into the work of an existing regulatory body. Develop clear standards and requirements for counselling services	Home Office	Steps identified and a decision made as to the potential of regulating private counsellors. Options for statutory regulation identified. Standards and requirements for counsellors agreed	October 2025 March 2026 October 2026	

Recommendation 4: Seek to raise awareness of the intersection of an individual's stressors (mental health, financial worries, bereavement) and wider factors (DA and suicide rates within LGBT communities & unconscious bias) across health professionals and local counselling services, that empowers those professionals to be able to recognise and respond appropriately to patients/clients.	Local	The NCSP team will develop a communications plan to detail how the findings of the report will be shared professionals and the public, prior to publication. The NCSP team will publish the report, enacting its comms plan	OPCCN/NCSP	Communication plan created. Communication plan enacted. Report published	April 2024 April 2024 December 2024	Partnership is provided with information on learning opportunities presented by this review
Recommendation 5: NCSP are to develop a coordinated awareness raising campaign to domestic abuse across the county's counsellors ensuring they are equipped to recognise and respond appropriately to domestic abuse.	Local	NCSP to host a webinar inviting counsellors from across Norfolk to a briefing about this DARDR and awareness raising regarding domestic abuse.	NCSP	Holding webinar	March 2025	
Recommendation 6: The learning from this review is shared across the partnership to raise awareness of domestic abuse, links to suicide, risk of intersectionality for gay male victims and all the learning opportunities raised.	Local	The NCSP team will develop a communications plan to detail how the findings of the report will be shared professionals and the public, prior to publication. The NCSP team will publish the report, enacting its comms plan	OPCCN/NCSP	Communication plan created. Communication plan enacted. Report published	April 2024 April 2024 December 2024	Partnership is provided with information on learning opportunities presented by this review

APPENDIX H: ONE PAGE SUMMARY

1. Domestic Homicide Review

Norfolk Office for Police Crime Commissioner commissioned this DARDR following Simon taking his own life in January 2022.

2. Case Summary

Simon was aged 42 at the time of his death. In January 2022, police were called to a report of a possibly deceased male inside a car at a public car park. Police and ambulance service attended and found Simon with a handwritten note to Thomas stating 'sorry' and an email had been sent to him. Emergency services attempted CPR, but life was pronounced extinct. Found inside the car was prescription methadone prescribed to Simon, and other tablets prescribed to a third party.

3. The Facts – an overview

Simon was one of four children, three boys and one girl. His parents had passed away and he remained very close to his sister.

Simon had lived in Norfolk with his Thomas for several years. Having met in 2008, they were married in 2014.

In 2016, Simon and Thomas had fostering responsibility for three children associated with a previous relationship of Simon's (Year 2000), with who they had periodic contact growing up.

The children moved on after a few years.

Simon and Thomas were business partners, with Simon leading a local care agency.

Simon was a man who had lived with mental and physical health for many years, having been diagnosed with bipolar affective disorder and chronic fatigue syndrome. In the years before his death, he was undergoing a series of diagnostic testing for a range of symptoms. He had also been prescribed methadone and having developed a methadone dependency had successfully addressed this challenge.

There was a history of failed attempts to take his own life including 2004 an overdose, and in 2005 by carbon monoxide poisoning, two attempts in 2006 and suicidal ideation in 2015 was linked with financial worries.

He was severely impacted by the passing of his mother (2014) and passing of his father (June 2021).

Whilst there had been no recent attempts to take his life since his relationship over the last few years with Thomas was difficult, and Simon wanted to have a divorce, whilst Thomas wanted to try and make it work.

The review identified that Simon had several health worries, appeared to be fearful of losing other close relatives, learned from Thomas that he had financial worries and that the relationship between Simon and Thomas was not happy.

Simon's family made an allegation of controlling and coercive behaviour after Simon's death that was investigated by the police and subject to no further action.

4. Learning Points

Professional Curiosity, Recognition and Response: Simon had significant contact with healthcare professionals and whilst he never raised concerns about domestic abuse, he was never asked about feelings of safety, nor did domestic abuse feature as part of routine screening.

4. Learning Points

Domestic Abuse - National Accreditation Standards for Counselling Services: Simon and Thomas both saw private counselors accredited by different organisations. Whilst domestic abuse (DA) did not feature and was not asked about, an examination of guidance notes for agencies showed opportunities to improve the identification of DA and raise the status of DA and ensure counselors are equipped to recognise and respond to DA.

Individual vulnerabilities: Importance of recognising individual stressors as contributory factors in understanding death by suicide, together with broader universal factors such as suicide and domestic abuse rates in LGBTQIA+ communities necessitating awareness raising across professionals, and to be taken account of when conducting equalities impact assessments and devising future domestic abuse and suicide prevention strategies.

Equalities and Intersectionality: The review highlighted the importance of completing Equalities Impact Assessments to inform strategy and service provision and shone a light on the intersection of sexuality and gender in respect of domestic abuse and suicide rates in the gay community, but also from the perspective from Simon's family that reinforced a need to raise awareness of DA in gay male relationships.

5. Good Practice

GP: (a) Simon benefitted from seeing the same GP over a period of time (b) positive working relationships between GP and 'Change Grow Live' to help Simon to successfully deal with methadone dependency

NNUH: Domestic abuse champions across hospital are a positive initiative.

Specialist male and LGBTQIA+ IDVA: Recognised as a positive development for marginalised communities.

Information Provision: Development of bespoke LGBTQIA+ material is welcomed.

6. Recommendations

R1: NCSP to ensure that an EINA and action plan is completed in relation to future Domestic abuse strategies.

R2: Update the template DA policy, bringing it up to date with changes in legislation, so as to encourage professionals to recognise indicators of, and routinely ask about domestic abuse.

R3*:* The Home Office are to seek to raise the status of domestic abuse (DA), exploring the potential of regulating private counsellors to ensure that DA is specifically cited within training requirements, and policy to ensure counsellors are equipped to recognise and respond to domestic abuse.

R4: NCSP: Seek to raise awareness of the intersection of an individual's stressors (*mental health, financial worries, bereavement*) and wider factors (*DA and suicide rates within LGBT communities & unconscious bias*) across health professionals and local counselling services, that empowers those professionals to be able to recognise and respond appropriately to patients/clients.

R5: NCSP are to develop a coordinated awareness raising campaign to domestic abuse across the county's private counsellors ensuring they are equipped to recognise and respond appropriately to domestic abuse.

R6: NCSP: The learning from this review is shared across the partnership to raise awareness of domestic abuse, links to suicide, risk of intersectionality for gay male victims and all the learning opportunities raised.